

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND 8321654 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH 8.5.83							2b. HOUR 842 A.M.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST HEROLD	MIDDLE D.	LAST BARBERRY	2a. DATE OF DEATH MONTH Oct 6 1981			MONTH	DAY	YEAR	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Oct 6 1921			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 61			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West. Va	
7a. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll			10. CITY OR TOWN OF DEATH Westminster			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Curroll County Gen. Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed Salesman			12b. KIND OF BUSINESS OR INDUSTRY 21157			10. CITY OR TOWN OF DEATH Westminster		
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5630 Bird View Rd			
14. FATHER'S NAME Connly		15. MOTHER'S MAIDEN NAME Bar Berry		16. SOCIAL SECURITY NO. 824-42-1101-00 212-18-3003		17. INFORMANT Elizabeth Ruth Barber			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> (c) <u>DIABETES MELLITUS.</u>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 9-26-82, 1982, to 10/0 1982, that (we) lost saw the deceased alive on 10/10 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. R. PRASAD			22c. DEGREE MD ATTENDING PHYSICIAN DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/5/83.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/9/83			23c. NAME OF CEMETERY OR CREMATORIAL Soraine Park			23d. LOCATION CITY OR TOWN Woodlawn Bld. Md		
24. FUNERAL DIRECTOR NAME Harry W. Haight			24. ADDRESS Sykesville			25a. DATE REC'D. BY REGISTRAR AUG 8 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy		
BP											

11079.3 - 11080.0 11081.0

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11137.0 - 11138.0 11139.0 - 11140.0

10

STATE OF MARYLAND 83 21655

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Genevieve R					Barlow	8	22	83	2 45 M	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White	MONTH	DAY	YEAR	70	MONTHS	WEEKS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Ohio	U.S.A.				CARROLL					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Westminster			336 Stoner Ave			Homemaker			Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			MD. 21157	
Md	Carroll	Westminster				336 Stoner Ave				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			JAMES	
George					Freeland	Genevieve				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
No			733-12-0425			Patricia Jacobs			13e 21157	
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYELOFIBROSIS</u>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS										
2898 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>ARTERIOSCLEROTIC HEART DISEASE</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 1966 to 8/22/83, that (I) (we) last saw the deceased alive on 8/22/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/22/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8-25-83			23c. NAME OF CEMETERY OR CREMATORIAL Meadow Brook			23d. LOCATION CITY OR TOWN Carroll COUNTY Westminster STATE Md		
24. FUNERAL DIRECTOR Robert Kyle Smith		ADDRESS Westminster, MD			25a. DATE REC'D. BY REGISTRAR AUG 29 1983			25b. REGISTRAR'S SIGNATURE Genevieve Barlow		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (reverse) is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from us or the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours; after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

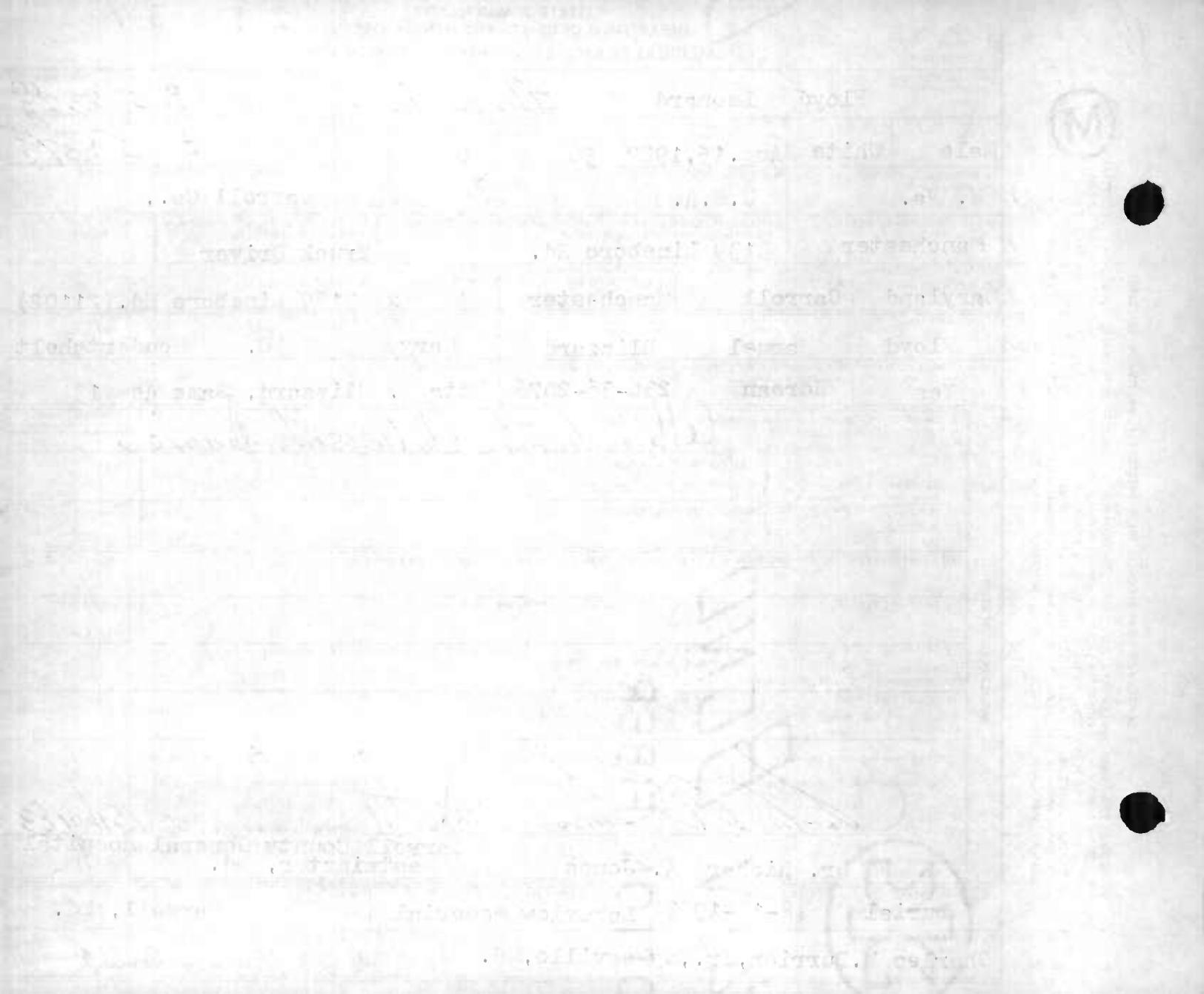
IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner may be required to do a post-mortem examination.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	21656					
										REG. NO.						
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		8 11 83			10. 50 AM			
JOSEPH F. BLAZER																
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
M			W			MONTH DAY YEAR			81			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			U. S. A.						Carroll							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY							
Westminster			Carroll County General			RECOG. OF PROFESSION OF YOUNG LIFE			ENGINEER B.O. Railroad							
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5001 Gwynn Oak Ave. 21207			MD.	
14. FATHER'S NAME FIRST Frank			MIDDLE			LAST Blazek			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE			LAST Wohnr	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			5001 Gwynn Oak Ave.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			705-05-7318			Joan Blazek			Baltimore Md. 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Acute inf wall M.I.						
1550																
DUE TO, OR AS A CONSEQUENCE OF (b) CA of liver																
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause, lost.																
DUE TO, OR AS A CONSEQUENCE OF (c) Hyperkalemia - Hyperkalemia																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-9 1983 to 8-11 1983, that (I) (we) saw the deceased alive on 8-10 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE Ricci MD										DEGREE	ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 2893 BALTIMORE BLVD. FINKSBURG, MD 21048													
RENZO RICCI, MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN Baltimore			COUNTY City		STATE Md.		
Burial			Aug. 13, 1983			New Cathedral										
24. FUNERAL DIRECTOR NAME			Eckhardt F. H. ADDRESS Owings Mills Md.			25a. DATE REC'D. BY REGISTRAR AUG 16 1983			25b. REGISTRAR'S SIGNATURE John Daniels							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, USE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF PUBLIC HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												21651							
												REG. NO.							
1- STATE REGISTRAR			Floyd Leonard																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED			2b. MONTH DAY YEAR				
Floyd Leonard									Blizzard			8/15/83			2b. HOUR 24 HOUR M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD					
Male		White		Aug. 15, 1927			56 yrs.			0		0		8/15/83			2d. MONTH DAY YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. DATE OF BIRTH MONTH DAY YEAR			8. MARRIED X NEVER MARRIED WIDOWED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH									
W. Va.		U.S.A.											Carroll Co.,			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Manchester			3139 Lineboro Rd.									Truck Driver							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Maryland			Carroll		Manchester						3139 Lineboro Rd. (21102)								
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME							
Floyd			Samuel						Blizzard			Mary			C. Houdertshelt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. DATE OF DEATH			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes			Korean			236-36-2076			8/15/83			Etta C. Blizzard, Same As #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.															DUE TO, OR AS A CONSEQUENCE OF				
															(b) DUE TO, OR AS A CONSEQUENCE OF				
															(c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											20. AUTOPSY?				
															YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>				and in my opinion							
ACTUAL SIGNATURE				Dr. Richard A. Jones				M.D.				TUL (SPECIES) Carroll County General Hospital Westminster, Md.				DATE SIGNED 15 Aug 83			
EXAMINER'S NAME (TYPE OR PRINT)				23a. BURIAL, CREMATION, REMOVAL (SPECIES)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION CITY OR TOWN			
Dr. Richard A. Jones				Burial				8-18-1983				Lakeview Memorial				Carroll, Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Charles W. Burrier, Jr., Sykesville, Md.												AUG 19 1983 John J. Conigli							



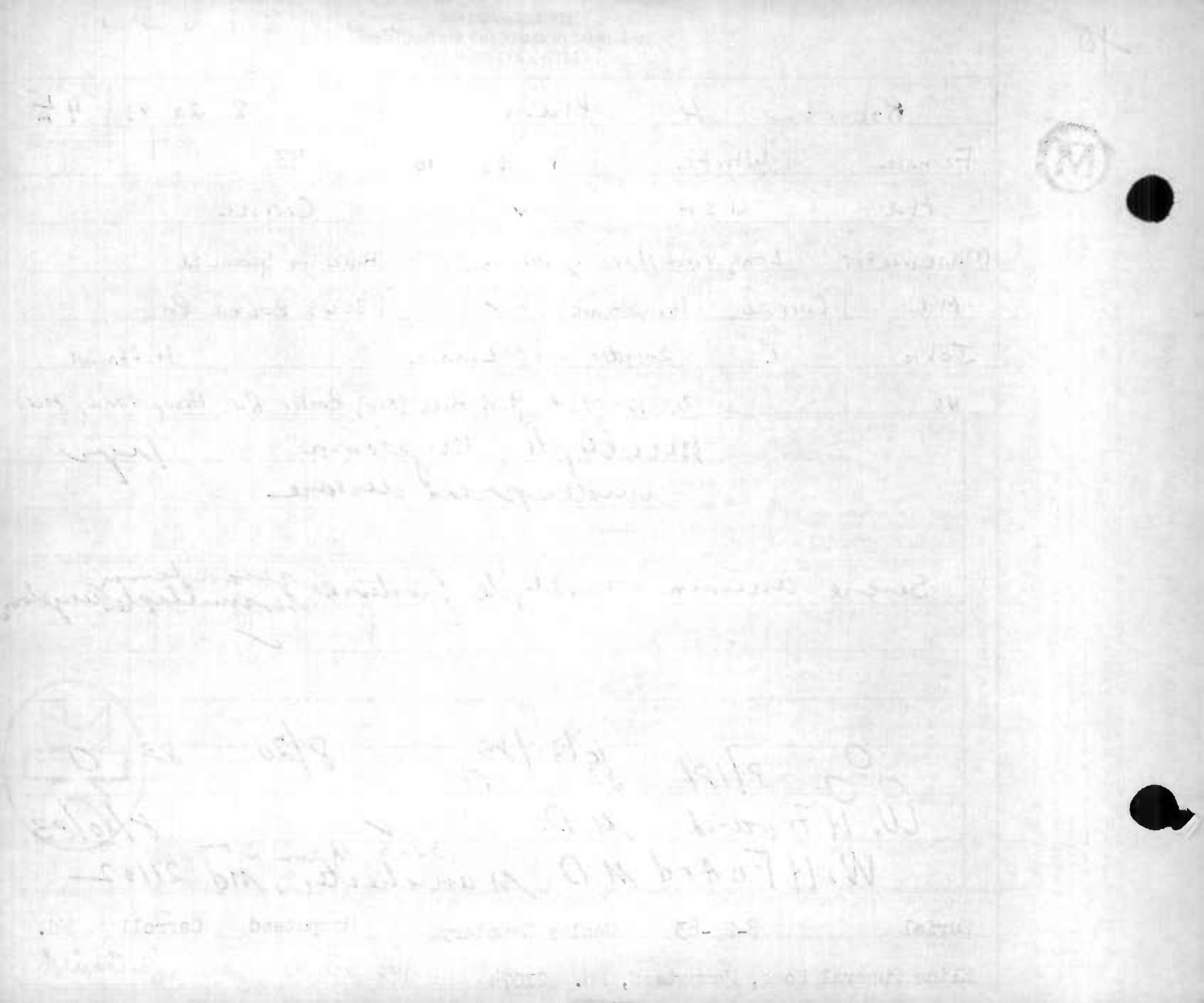
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retdned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 21 658						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Robert H. Blum												8 20 83				4 1/2 AM		
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH DAY YEAR			1 23 10			73		YRS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Md.			U.S.A.									Carroll						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Manchester			Long View Nursing Home									Aide for Special Ed		21074				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Md			Carroll		Hampstead			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3569 Basler Rd.							
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME									
John			E			Snyder			Linnie			LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS						
NO			213-16-0854						Multiple myeloma underspread disease			2030						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			(b)			(c)			DUE TO, OR AS A CONSEQUENCE OF			AND/OR STATE INTERVAL BETWEEN DEATH AND IMMEDIATE CAUSE						
DUE TO, OR AS A CONSEQUENCE OF			underspread disease									Type						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
Serene anemia + multiple fractures secondary to multiple myeloma																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/25/83 to 8/20/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) hold liable only the hospital after death.			19 83			19 83			8/20			19 83		O				
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
W.H. Howard M.D.									8/20/83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23d. LOCATION CITY OR TOWN												
W.H. Howard M.D.			3223 Main St Manchester, Md 21102			Hampstead			Carroll			Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN									
Burial			8-23-83			Wesley Cemetery			Hampstead									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Eline Funeral Home, Hampstead, Md. 21074						AUG 23 1983			John J. Conner									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	21659				
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
NICHOLAS Otto BOEHL						8 21 83			1720 M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Male		White		Jan. 27, 1908			75 YRS.			8 24 HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		U.S.A.					Carroll Co.,								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster		Carroll Co. General Hospital								Superiorvisor			Cab Co.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Woodbine					5616 Bethel Rd. (21797)						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Otto Mathew Boehl			Daisy Bower												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			213-05-7885			Tresa C. Boehl, Same As #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
7070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										CARBON PULMONARY ARREST					
DUE TO, OR AS A CONSEQUENCE OF (b)										SEPTIC SHOCK					
DUE TO, OR AS A CONSEQUENCE OF (c)										GANGRENOUS DECUBITI					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 DEHYDRATION															
19a. DATE OF OPERATION 12, 13, AUG 83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DEBRIDEMENT OF DECUBITI						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-12, 19 83, to 8-21, 19 83, that (I) (we) last saw the deceased alive on 8-21, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death															
22b. SIGNATURE G.V. PRASAD.										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (IN CAPS)										22e. ADDRESS CARROLL COUNTY HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL 1. SPECIFY: Burial			23b. DATE 8-24-1983			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Meadowridge			23d. LOCATION CITY OR TOWN Baltimore, Md.			25e. REGD. BY REGISTRAR REGISTRAR'S SIGNATURE AUG 24 1983 John J. Conner			
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.															
BP															
DHMH - 16 50M 1/81 (VRA 15, 4)															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21660			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH			
Edna		May					Cain			8/18/83			
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR		
Female		White			MONTH 5 DAY 7 YEAR 12			71			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.A.						Carroll			sewing factory		
10. PLACE OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
21157 Westminster		Carroll County General Hosp.											
13a. STATE		13b. COUNTY		13c. TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21776			
Maryland		Carroll		New Windsor		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		233 Main St.					
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		Alberta Fritz			
Charles								FIRST		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		none		212-01-8631		Alice M. Eckard		New Windsor, MD		month			
1539								metastatic cancer		month			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)				(b)		adeno carcinoma				month			
				(c)		of the colon							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CHY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8-5, 1983, to 8-18, 1983, that (I) (we) last saw the deceased alive on 8-18, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE		22c. DATE SIGNED				8-15-83			
Ephraim Barzaga		our											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>							
Ephraim Barzaga		NEW WINDSOR, MD. 21776											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ESTATE, CITY, TOWN				23d. COUNTY STATE					
Burial		8/21/83		Pipe Creek Cemetery New Windsor Carroll MD									
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE OF DEATH BY REGISTRAR, REGISTRAR'S SIGNATURE									
Q. D. Hartler		New Windsor, Md.		AUG 22 1983									

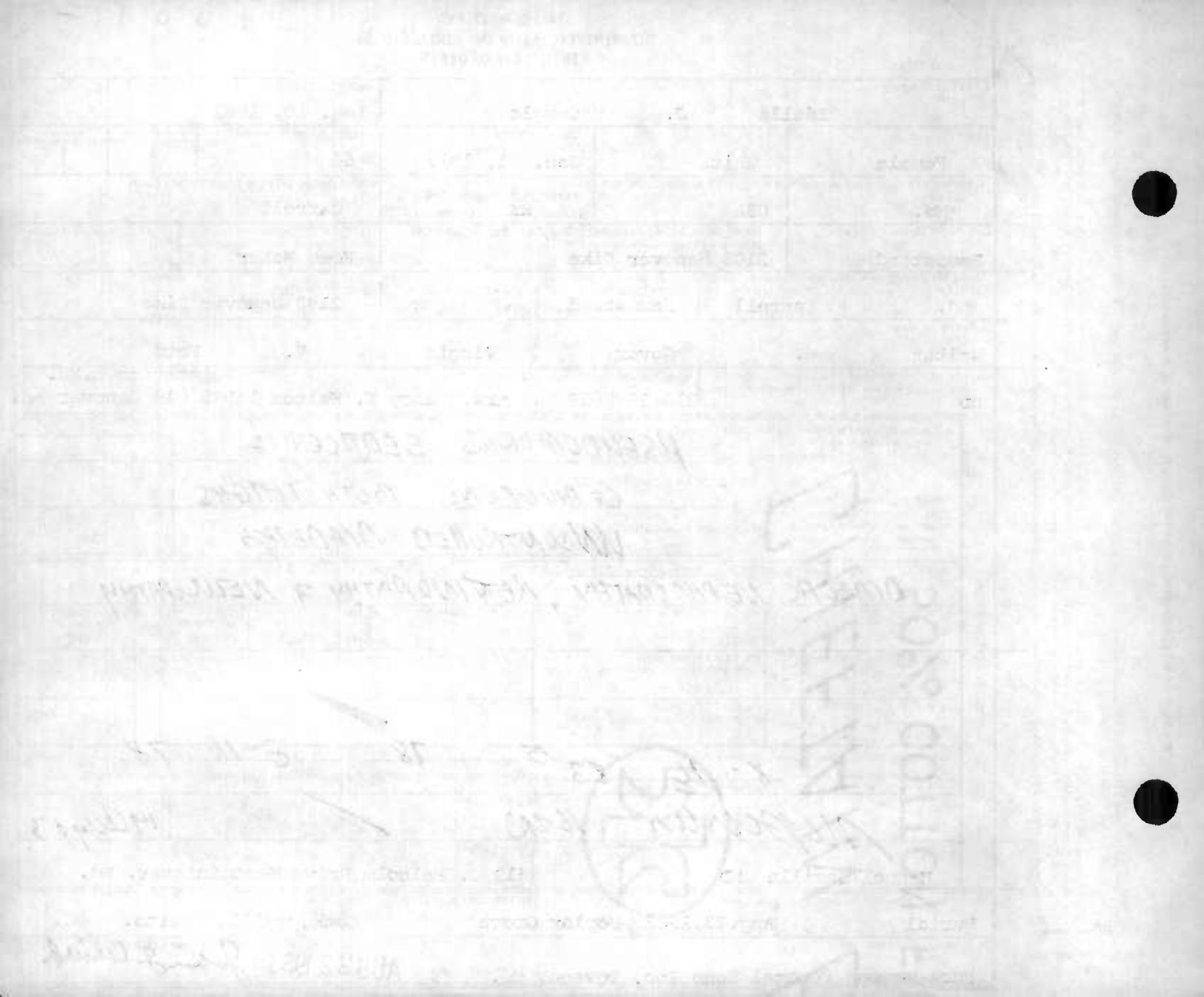
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21661						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Idella J. Cougle						Aug. 18, 1983									M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1917			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll									
10. CITY OR TOWN OF DEATH Hampstead			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2103 Hanover Pike			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2103 Hanover Pike		21074						
14. FATHER'S NAME FIRST MIDDLE LAST Walter W. Gover			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virgie V. Ford													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 216-28-9659			17. INFORMANT Mrs. Nancy L. Walton			ADDRESS Reisterstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PSEUDOMONAS SEPTICEMIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHANGRENE BOTH THIGHS</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>UNCONTROLLED DIABETES</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>DIABETIC NEPHROPATHY, RETINOPATHY & NEUROPATHY</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5</u> 19 <u>78</u> , to <u>8-16</u> 19 <u>78</u> , that (I) (we) last saw the deceased alive on <u>8-16</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Manuel Sevilla</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>19 Aug 83</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Manuel Sevilla MD			22e. ADDRESS 419 C. Malcolm Drive Westminister, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 23, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Poplar Grove			23d. LOCATION CITY OR TOWN Cockeysville			COUNTY Balto.		STATE Md.		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home Inc. Towson, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 22 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Cawich</u>							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

83-21662

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN DEATH OCCURRED	MONTH	DAY	YEAR	2b. HOUR	
Sheron (Sharon)			A.	Daniels		ESTIMATED	8	9	1983	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.						
Female	Black	3 3 59	24 yrs.								
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?			11. MARRIED WIDOWED	12. NEVER MARRIED DIVORCED	13. BALTIMORE CITY OR COUNTY OF DEATH			12d. HOUR	
Maryland		U. S. A.					Carroll County, MD.			9:00 a.m.	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Westminster		North Nicademus Bridge Road			16a. STATE Maryland	16b. COUNTY Baltimore	16c. CITY OR TOWN Baltimore	17a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	17b. STREET ADDRESS 3322 Northmont Road 21207	17c. ADDRESS	Hickson
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		19. SOCIAL SECURITY NO.			20. MOTHER'S MAIDEN NAME			21. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
NO		N/A			Chirstine			George Daniels 3322 Northmont Road			
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9102 IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			24. AUTOPSY?			
23a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		23b. TIME OF INJURY EST. HOUR A.M. MONTH DAY YEAR ? P.M. 8 9 19 10			23c. subject drowned while swimming			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
23d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		23e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water			23f. LOCATION STREET North Nicademus Bridge Rd., Westminster, CITY OR TOWN Carroll Co., Md.			CITY OR TOWN COUNTY STATE			
25a. I certify that I am in charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion											
26. ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i> Assistant MEDICAL EXAMINER DATE SIGNED 8-10-83											
27a. EXAMINER'S NAME (TYPE OR PRINT)		27b. ADDRESS 111 Penn Street			27c. BURIAL, CREMATION, REMOVAL (SPECIFY)			27d. LOCATION CITY OR TOWN Baltimore Co. Md.			
28. FUNERAL DIRECTOR NAME WM C March F/H Inc.		28b. ADDRESS 1101 E North Ave.			28c. DATE 8/15/83			28d. DATE REC'D. BY REGISTRAR AUG 11 1983			
29. REGISTRAR'S SIGNATURE <i>John G. Lavelle</i>											

35b

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 21663			
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH 8/3/83			MONTH 8	DAY 3	YEAR 83	2b. HOUR M
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH 9 DAY 15 YEAR 06			6. AGE (IN YEARS LAST BIRTHDAY) 76			IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.						
10. CITY OR TOWN OF DEATH Finksburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3742 Niner Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer			12b. KIND OF BUSINESS OR INDUSTRY Retired						
13a. STATE Md.			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3630 Beech Ave. 21211			
14. FATHER'S NAME FIRST Walter			MIDDLE Dix			15. MOTHER'S MAIDEN NAME FIRST Dora									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-10-1780			17. INFORMANT Helen E. Dix			ADDRESS 3630 Beech Ave. Balto. 21211						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4960</u> <u>Pneumonia</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Chronic obstructive</u> DUE TO, OR AS A CONSEQUENCE OF <u>Pulmonary Disease</u> 3 yrs.												BETWEEN ONSET AND DEATH 4 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) <u>John Seitz, Jr.</u> attended the deceased from <u>July 8</u> 19 <u>83</u> to <u>July</u> 19 <u>83</u> , that (I) <u>John Seitz, Jr.</u> last saw the deceased alive on <u>July 8</u> 19 <u>83</u> , and that in (my) <u>John Seitz, Jr.</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>John Seitz, Jr.</u> (did not) view the body after death.												22c. DATE SIGNED 8/4/83			
22b. SIGNATURE <u>Alan B. Cohen</u>			22d. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Alan B. Cohen, M.D.			22f. ADDRESS 201 East University Pkwy. Baltimore, Maryland 21218												
23a. BURIAL, CREMATION, REMOVAL (SPEC #) Burial			23b. DATE 8/5/83			23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park			23d. LOCATION CITY OR TOWN Baltimore			COUNTY STATE Md.			
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.			ADDRESS 3818 Roland Ave. Balto. Md.			25a. DATE REC'D. BY REGISTRAR AUG 4 1983			25b. REGISTRAR'S SIGNATURE <u>John Seitz, Jr.</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return the certificate to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from or the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified and advised.

MEDICAL CERTIFICATION

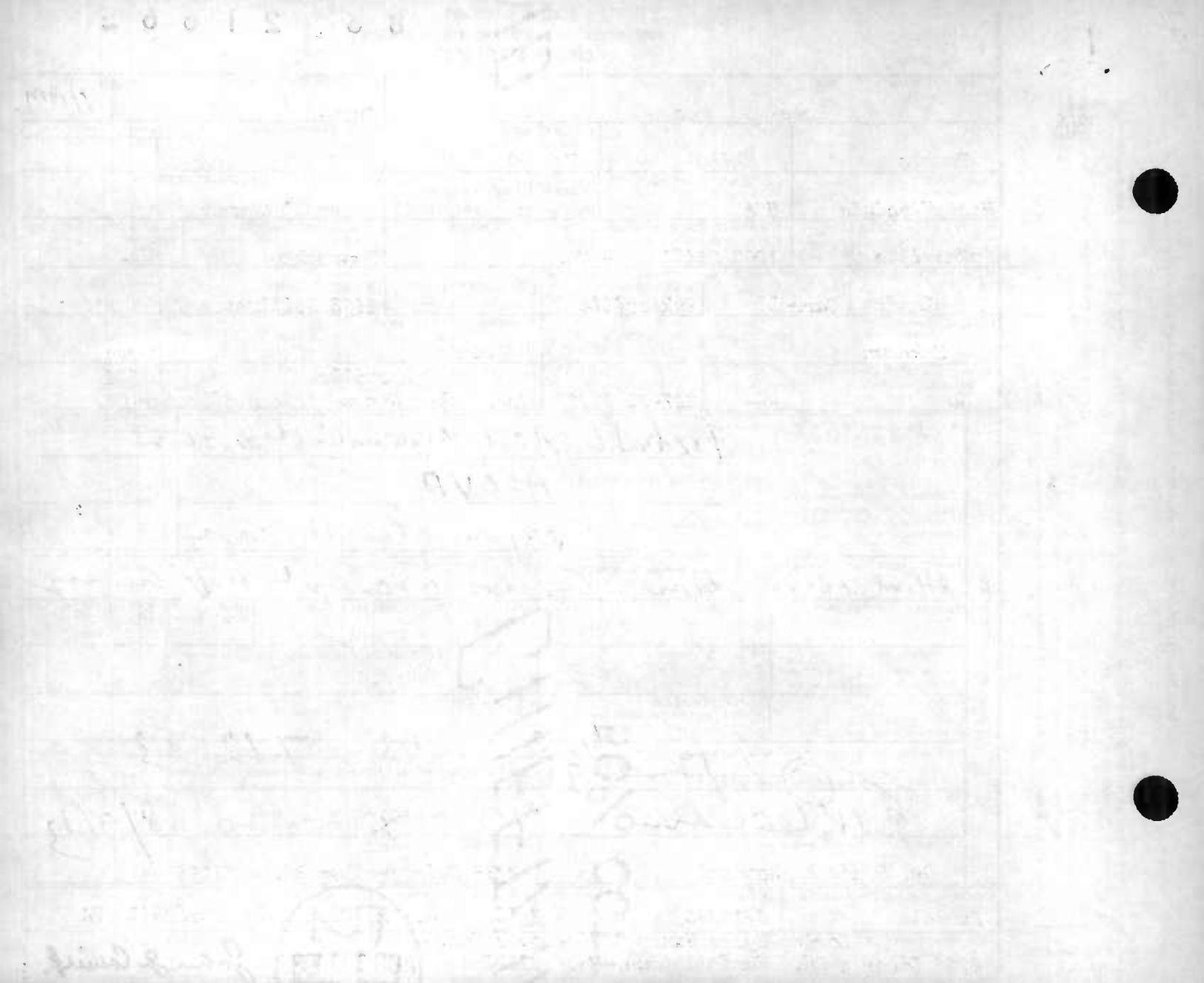
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21664						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Leroy Francis Duvall									8 9 83					5:30 A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		9. IF UNDER 24 HRS			
Male			Caucasian		April 18 31		52		MONTHS		DAYS		HOURS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		11. KIND OF BUSINESS OR INDUSTRY					
Md			USA				Carroll County		Truck Driver		Transportation					
12. CITY OR TOWN OF DEATH			13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY					
Westminster			Carroll County General Hosp.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1405 Woods Mill Rd.		Truck Driver		Transportation					
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			19. SOCIAL SECURITY NO.		20. INFORMANT ADDRESS		21. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH									
NO			—		Elizabeth Mary Duvall		ACT									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE																
DUE TO, OR AS A CONSEQUENCE OF (b) SMALL CELL CARCINOMA OF LUNG																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 83 to AUGUST 9 19 83, that (I) (we) last saw the deceased alive on JULY 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED					
Howard G. Vaughan, MD											8/19/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS		22f. ADDRESS											
HOWARD G. VAUGHN, MD			215 WASHINGTON HTS MED CTR. WESTMINSTER													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL MEMORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial			8/11/83		Crest Lawn Memorial		Marriottsville		Howard		Md					
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Harry W. Haught			Sykesville		AUG 10 1983		John J. Connelly									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21665						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Rose Mae Due												August 9, 1983				11 AM
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH DAY YEAR			76			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia			USA			Feb 20, 1907			Carroll County			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS?			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Sykesville			1903 Stillwater Ct.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Homemaker			---				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS							
Maryland			Carroll			Sykesville			1903 Stillwater Ct. 21784							
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME							
Cleve			Hagy						Vicie			Elkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			13e. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			227-09-5942D			Sykesville, MD 21784			Mrs. Debra Nixon 1903 Stillwater Ct.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable Acute Myocardial Infarction</i>																
4100 DUE TO, OR AS A CONSEQUENCE OF <i>AsxvD</i> (b) _____																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Posterior artery disease</i>																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Obesity, hypertension, cerebrovascular insufficiency</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>4-8-83</i> to <i>7-12-83</i> , that (I) (we) last saw the deceased <i>19-8-83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																
27a. SIGNATURE <i>Swadesh Bhatiani</i>			27b. DEGREE <i>M.D.</i>			27c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			27d. DATE SIGNED <i>8/9/83</i>							
28. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23d. LOCATION CITY OR TOWN			25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>							
Dr. Swadesh Bhatiani						Richlands			Tazewell			VA STATE				
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION							
Burial			8/12/83			Clinch Valley Mem. Pk.			Richlands							
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Loring Byers Funeral Directors, Inc.																
8728 Liberty Rd. Randallstown, Md. 21133						AUG 10 1983										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after it is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Jean Hazel Frederickson						8 30 83			2100 M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 16, 1919			6. AGE (IN YEARS LAST BIRTHDAY) 64		IF UNDER 1 YEAR 7 14		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penns.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.,						
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY (21797)				
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2809 Gillis Falls Rd.				
14. FATHER'S NAME FIRST MIDDLE LAST Harry R. Hazel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian Bodycomb										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Roderic W. Frederickson, Same As #13			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4939			DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHIAL ASTHMA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)						YEARS				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (II) (we) (did) (did not) view the body after death			8/30 1983			8/30 1983							
22b. SIGNATURE Jean Hazel Jr. MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/20/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. SUREL, MD			22e. ADDRESS CARROLL CO. HOSPITAL										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-3-1983			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive			23d. LOCATION CITY OR TOWN Carroll, Md.			23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.						25a. DATE REC'D. BY REGISTRAR SEP 6 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy				

1932. Introducing Choices

5
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21661				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Scott F FRITZ						8 31 83					00 05	M		
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
Male			White			2 12 08			95			IF UNDER 1 YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Md			U.S.						Carroll			MONTHS DAYS HOURS MIN.		
9. YRS.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Westminster			Carroll County Hospital			railroad			railroad			MD.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Md.			Carroll			New Windsor			YES			229 Main St. 21153		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
Lewis					Fritz	Ada								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			n/a			705-10-4904			Wife			Vallie W. Fritz 21153		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ischemia</u> 4439 <u>Googooe Both legs, L arm</u> 4 DAYS DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Peripheral Vascular Disease</u> 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Bronchitis</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/30, 1983, to 8/31, 1983, that (I) (we) last saw the deceased alive on 8/30, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Norman Goldstein</u>			22c. DEGREE M.D. - ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. ADDRESS 218 Washington Heights Blvd Ct Westminster, Md			22e. DATE SIGNED 8/31/83					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/2/83			23c. NAME OF CEMETERY OR CREMATORIAL BEAVER DAM			23d. LOCATION CITY OR TOWN			COUNTY STATE		
burial														
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE								
PRITTS F.H.			WESTMINSTER, MD			SEP 8 1983			John J. Carroll					

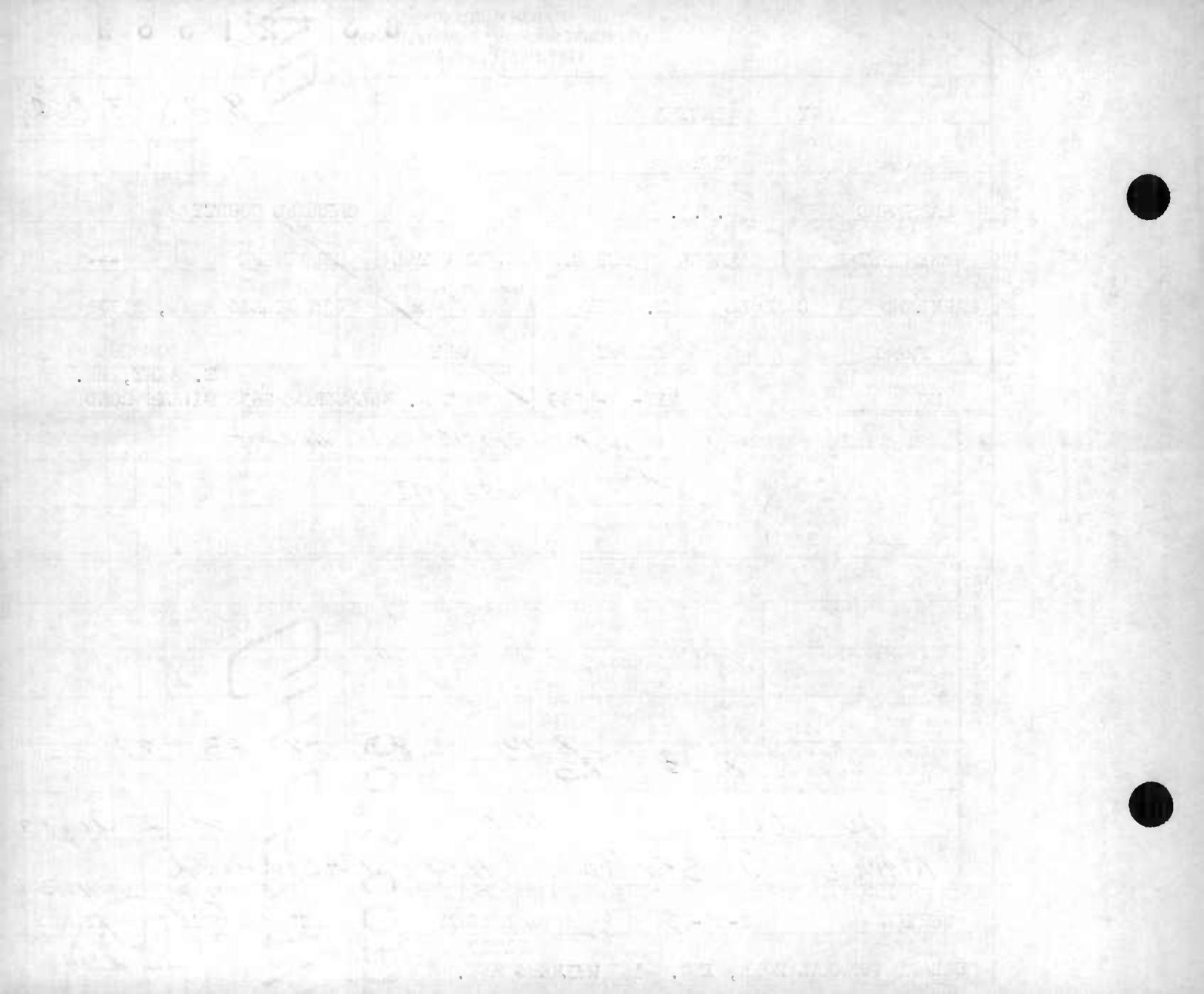
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 23 83	21668
1. DECEASED NAME FIRST MIDDLE LAST										2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR AM PM
MARY REGINA FROEB										8 23 83	0228
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 01 DAY 11 YEAR 13			16 AGE (IN YEARS LAST BIRTHDAY) 70 YRS			17 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY			10 CITY OR TOWN OF DEATH WESTMINSTER	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HOSPITAL										12a. USUAL OCCUPATION HOUSEWIFE	
13a. STATE MARYLAND 13b. COUNTY CARROLL 13c. CITY OR TOWN MT. AIRY										13b. KIND OF BUSINESS OR INDUSTRY MD.	
14. FATHER'S NAME FIRST FRANK		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MARY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2635 GILLIS ROAD, 21771	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 213-07-9589		17. INFORMANT ROBERT A. BELLUOMO			18. ADDRESS MT. AIRY, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: CARDIO-RESPIRATORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF ACUTE MI.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8-28-83, 19, to 8-23-83, 19, that (I) (we) last saw the deceased alive on 8-28-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 23 Aug 83	
22b. SIGNATURE M. J. Senilla		22d. DEGREE MD			22e. ADDRESS 419 Malcolm St.						
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Manuel J. Senilla		22g. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 08-26-83		23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK			23d. LOCATION CITY OR TOWN BALTIMORE CITY COUNTY MARYLAND STATE		25a. DATE RECEIVED BY REGISTRAR AUG 26 1983		25b. REGISTRAR'S SIGNATURE John G. Smith
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.										25c. REGISTRAR'S SIGNATURE	

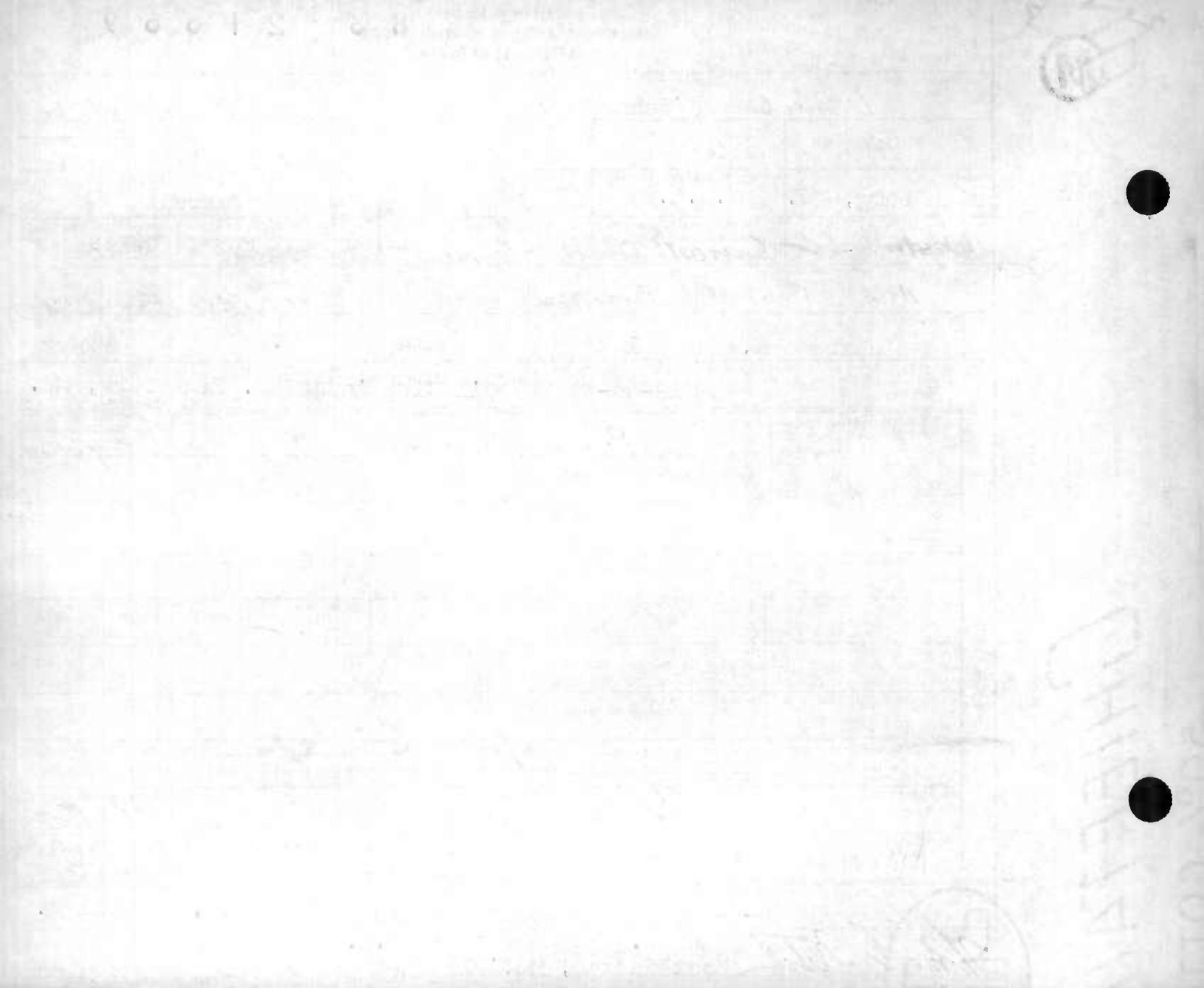


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21669								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Daniel			Richard			Gist						8 2 83			11 a.m.					
3. SEX		M		4. RACE		W		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
								MONTH		9 23 51		31		MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Finksburg, Md.		7b. CITIZEN OF WHAT COUNTRY?		U.S.A.		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Carroll		MD				
10. CITY OR TOWN OF DEATH		Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Carroll County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Instructor		12b. KIND OF BUSINESS OR Employing School		21048						
13a. STATE		Md		13b. COUNTY		Carroll		13c. CITY OR TOWN		Finksburg		13d. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		2911 Club House Rd.		
14. FATHER'S NAME		Richard		M.		Gist		15. MOTHER'S MAIDEN NAME		Ruth		B.		Abbott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		Bo		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		219-60-3452		17. INFORMANT		Mrs. Ruth B. Gist		ADDRESS		2911 Club House Rd. Finksburg, Md.		21048				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) 2396												34 years								
DUE TO, OR AS A CONSEQUENCE OF (b)																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET						CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												19 83								
22b. SIGNATURE Norman Goldstein M.D.												22c. DATE SIGNED 8/2/83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									218 Washington Hts Med Ctr Westminster Rd 21152								
Norman Goldstein																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION											
Burial			8-5-83			Sandymount Cemetery			Finksburg, Carroll Md.											
24. FUNERAL DIRECTOR NAME			24a. DATE REC'D. BY REGISTRAR									25b. REGISTRAR'S SIGNATURE								
Thomas D. Fletcher & Son F.H. 54 East Main St. Westminster, Md. 21157			AUG 5 1983									John J. Smith								

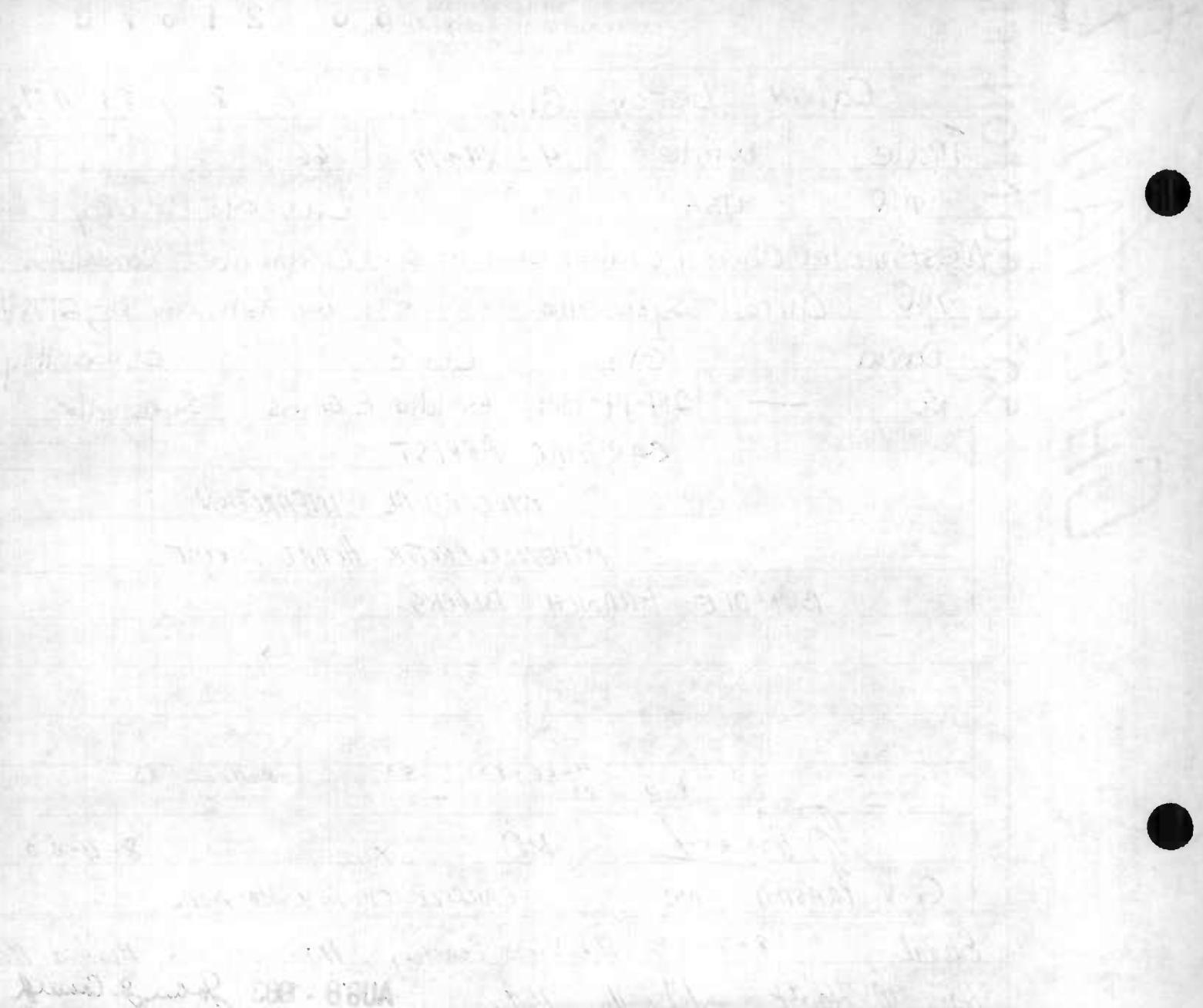


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 21670						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Calvin Leroy Glass Sr.												8-4-83					11 19 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male			White			MONTH 4 - DAY 24 - YEAR 17			66			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Md			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll County			Carpenter		Construction				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Westminster			Carroll County Gen. Hosp.															
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Md			Carroll			Sykesville			YES			104 Bethway Dr, 21784						
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			LAST						
David						Glass			Clara			Esworthy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO			214-14-9319			Goldia E Glass			Sykesville									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>																		
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> (c) <u>ATHEROSCLEROTIC HEART DISEASE</u>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>BUNDLE BRANCH BLOCKS.</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
-			-			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (s) (this hospital) attended the deceased from 7-26-83 1983 to 8-4-83, that (s) (we) last saw the deceased alive on 8-4-1983, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (s) (we) did not view the body after death.																		
22b. SIGNATURE <u>G.V. Prasad</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-4-83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.V. Prasad MD			22e. ADDRESS CARROLL COUNTY HOSPITAL															
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 8-5-83			23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery			23d. LOCATION CITY OR TOWN Marriottsville			COUNTY	STATE					
24. FUNERAL DIRECTOR NAME Harry W. Haight			ADDRESS Sykesville, Md.			25a. DATE REC'D. BY REGISTRAR AUG 8 - 1983			25b. REGISTRAR'S SIGNATURE John J. Conner									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 21671			
										REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Haifley, Leighton R										August 24 1983		1802M	
3. SEX		4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		white			10 04 10			72		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Md.		U.S.						Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Westminster		Carroll Co. General Hosp.			Builder			Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21157			
Md.		Carroll		Westminster				122 Carroll View Av.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Frank		Sarah											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS		21157				
no		n/a			220-18-3266		Layne Haifley						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>													
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Dementia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
19a. DATE OF OPERATION										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>August 24 1983</u> to <u>August 24 1983</u> , that (I) (we) last saw the deceased alive on <u>August 24 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <u>did not</u> view the body after death.													
22b. SIGNATURE <u>John S. Harshey, MD</u>		DEGREE								ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>21157</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John S. Harshey, MD</u>		22e. ADDRESS <u>21157</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 8/26/83			23c. NAME OF CEMETERY OR CREMATORIAL Pipe Creek			23d. LOCATION CITY OR TOWN Linwood		COUNTY Carroll		STATE MD	
24. FUNERAL DIRECTOR NAME PRITTS F.H. WESTMINSTER		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
					AUG 29 1983		<u>John S. Carroll</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 83 21672

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
John T. Harant						Aug. 31, 1983				5 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		July 8, 1897		86		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. Md. MD.					
Balto. Md.		USA									
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ind. Eng.		12b. KIND OF BUSINESS OR INDUSTRY					
Md.		Balto		Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 400 Valley Meadow Circle		21136	
14. FATHER'S NAME John Harant		15. MOTHER'S MAIDEN NAME Carolina Fuchs									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Yes WWI 115-03-6801		17. INFORMANT Dr. Loyal Harant		ADDRESS Reisterstown, Md.					
								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1889		Causes respiratory arrest of bladder									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DOUE TO, OR AS A CONSEQUENCE OF (b)									
		DOUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/27, 19 05, to 8/31, 19 85, that (I) (we) last saw the deceased alive on 8/30/83 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Renzo Ricci		22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 8/31/83							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Renzo Ricci		22f. ADDRESS Finksburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Sept. 3, 83		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		23d. LOCATION CITY OR TOWN Baltimore		COUNTY		STATE	
						City		Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home		ADDRESS Reisterstown, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE SEP 6 1983 John Harant					

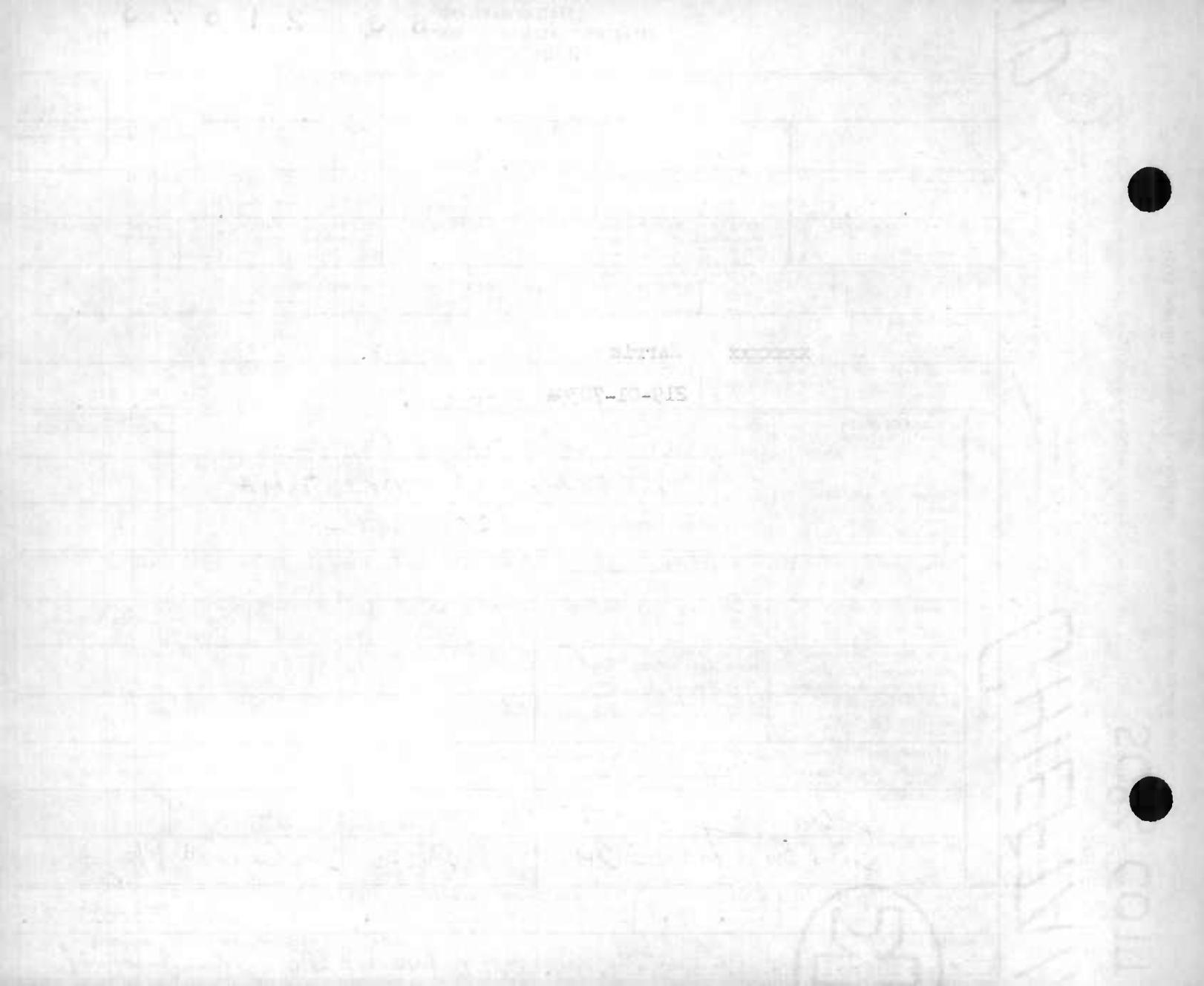
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or present.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21673											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR									
GEORGE			WASHINGTON		HARRIS	Aug. 7, 1983						11 P.M.									
3. SEX			4. RACE		5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR								
Male			White		May 9, 1903					80 YRS.			MONTHS DAYS HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Balto. Co. Md			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Carroll Co.			Hampstead			2938 Hampstead Mexico Rd.			Truck Driver			21074		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
Md.			Carroll		Hampstead		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Hampstead Mexico Rd.											
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Amos B. Harries					Harris	Mary I. Baublitz			No			219-01-7839A			George B. Harris			Hampstead, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest.</i>																					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>METASTATIC CARCINOMA</i>																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>PROSTATE.</i>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>June 19, 1983</i> to <i>1983</i> , that (I) (we) last saw the deceased alive on <i>June 19, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED						
22b. SIGNATURE <i>John Baublitz MD</i>															22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						23d. LOCATION CITY OR TOWN Hampstead COUNTY Carroll STATE Md.												
SURESH M. SODH			Suite 2 Carroll Plaza																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION												
Burial			Aug. 10, 83			Snydersburg Cem			CITY OR TOWN Hampstead COUNTY Carroll STATE Md.												
24. FUNERAL DIRECTOR NAME Eline Funeral Home Hampstead, Md. 21074															25a. DATE REC'D. BY REGISTRAR						
															25b. REGISTRAR'S SIGNATURE <i>John Baublitz</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21674									
												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
<i>Norman H. Henley</i>									<i>Henley</i>			8 15 83				8 15 83	11 ⁴⁵ AM				
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH MONTH <i>8</i> DAY <i>22</i> YEAR <i>98</i>			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>84</i> DAYS <i>YRS</i>			7. DATE REC'D. BY REGISTRAR		21 AUG 16 1983		21. REGISTRAR'S SIGNATURE <i>John J. Colleigh</i>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i>			10. CITY OR TOWN OF DEATH <i>Sukesville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sukesville Eldercare Center</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>2163</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Howard</i>			13c. CITY OR TOWN <i>Woodstock</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>10860 Rt. 99</i>			14. FATHER'S NAME FIRST <i>Notley</i> MIDDLE <i>H.</i> LAST <i>Henley</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Alice</i> MIDDLE <i>Jackson</i> LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218-14-7740</i>			17. INFORMANT <i>Evelyn Henley</i>			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c) PART 1. DEATH WAS CAUSED BY: <i>4292</i> IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Asp VD c CTF; Alice Baker.</i>			19. MEDICAL CERTIFICATION		20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>8. 80</i>			21f. LOCATION STREET <i>8811 Liberty Rd. Randalstown, MD 21130</i>			21g. CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8. 80</i> to <i>8. 15</i> on <i>19 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <i>BABUY-R. MD.</i>			22c. DEGREE <i>MD</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BABUY-R. MD.</i>			22e. ADDRESS <i>8811 Liberty Rd. Randalstown, MD 21130</i>			22f. DATE SIGNED <i>21 AUG 16 1983</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIES) <i>Burial</i>			23b. DATE <i>8-18-83</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. View Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Marshall Howard MD</i>			24. FUNERAL DIRECTOR NAME <i>Harry W. Hight</i>		24e. ADDRESS <i>Sukesville, Md.</i>			24f. DATE REC'D. BY REGISTRAR 24g. REGISTRAR'S SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

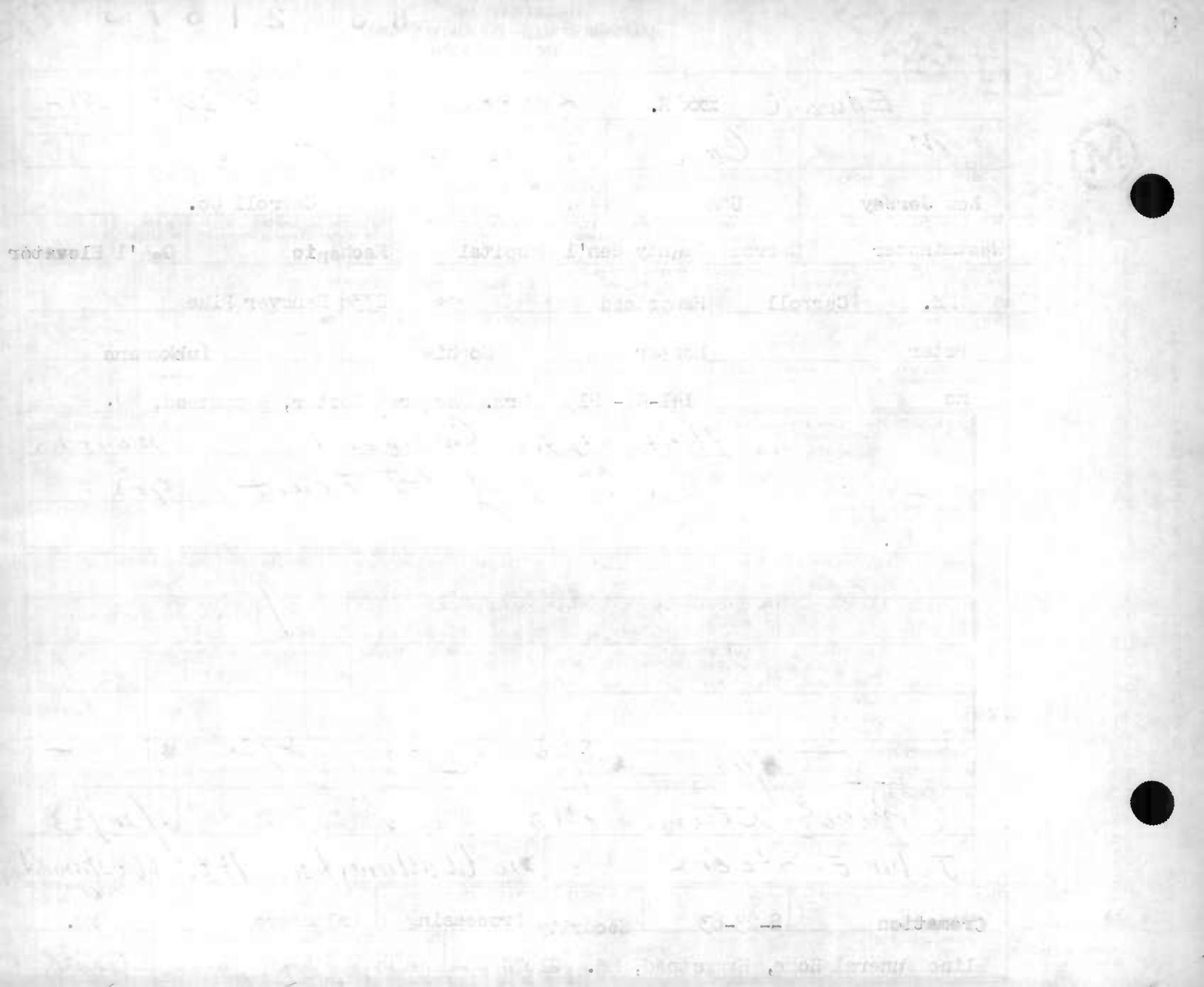
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 2 1 6 7 5							
												REG. NO.							
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST Edward			MIDDLE R.			LAST Koster			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
															8/20/83			0554 AM	
3. SEX M			4. RACE Can			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS				
						CO 12 15			67			YRS.			MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.			MD.							
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen'l Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Gen'l Elevator										
13a. STATE Md.			13b. COUNTY Carroll			13c. CITY OR TOWN Hampstead			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2336 Hanover Pike			21074				
14. FATHER'S NAME FIRST Peter			LAST Koster			15. MOTHER'S MAIDEN NAME FIRST Sophie			MIDDLE Lukkemann										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> no			16b. SOCIAL SECURITY NO. 141-07-4219			17. INFORMANT Mrs. Margaret Koster, Hampstead, Md.			ADDRESS										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1599 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months							
1b) DUE TO, OR AS A CONSEQUENCE OF 1599 Metastatic Carcinoma Cancer of GI tract																			
1c) DUE TO, OR AS A CONSEQUENCE OF Cancer of GI tract												4 yrs.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) this physician attended the deceased from 8/10/83 to 8/20/83, that (I) (we) last saw the deceased alive on 5/19/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE John E. Steers			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/20/83										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Steers			22f. ADDRESS 210 Washington St. Westminster, Md.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-23-83			23c. NAME OF CEMETERY OR CREMATORIAL Security Processing			23d. LOCATION CITY OR TOWN Baltimore			COUNTY STATE Md.							
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 23 1983			25b. REGISTRAR'S SIGNATURE John J. Cawieh										

BP

DHMH-16 25M
(VRA 15, 4) 1/79



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copy prior to burial, cremation, or removal, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

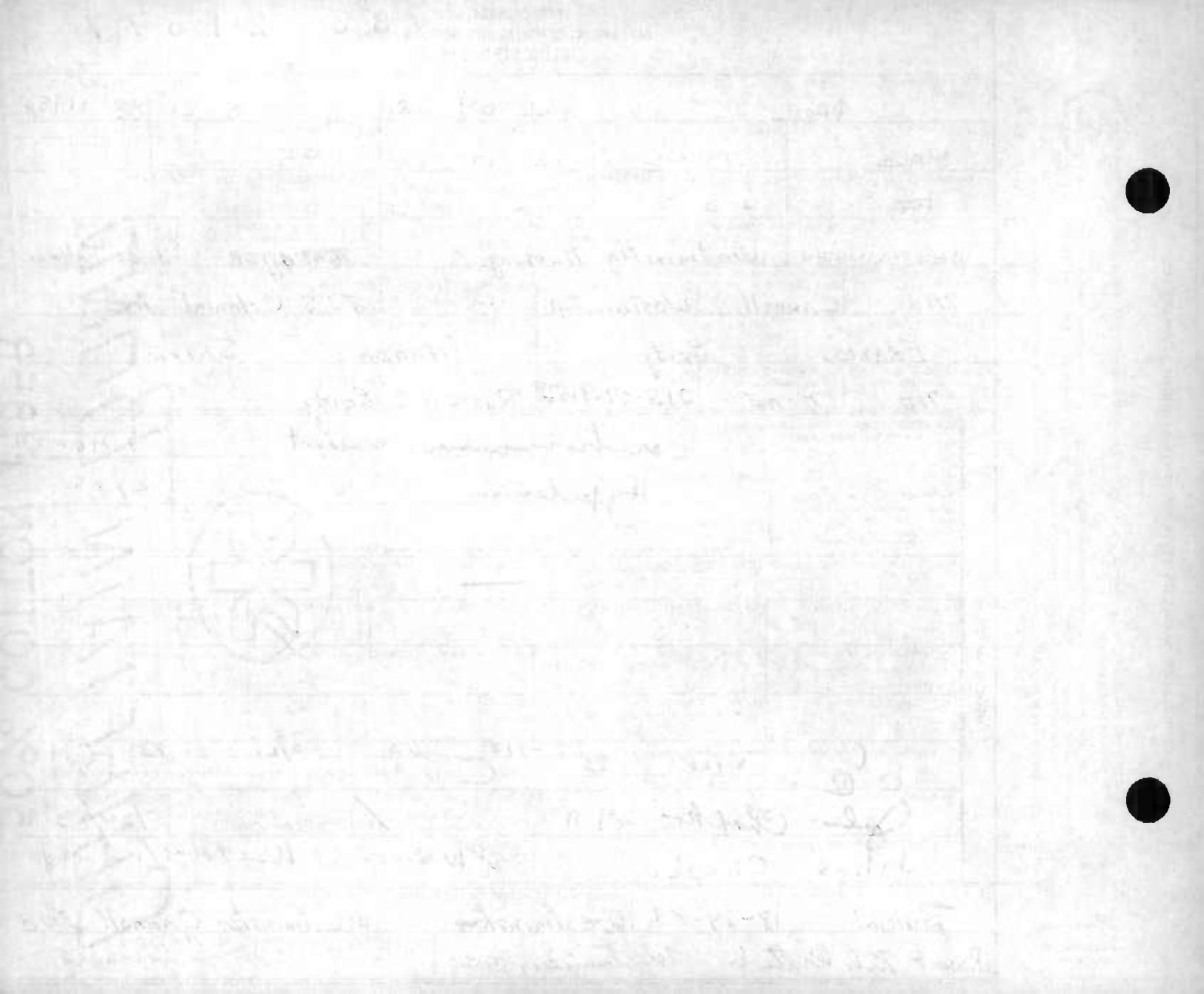
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	21676				
1- FOR - STATE REGISTRAR		REG. NO.													
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
IRENE B. KREIMER						8-29-83			83	29	1983	132 pm			
3 SEX		4 RACE		5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Caucasian		MONTH DAY YEAR			100			MONTHS	YEARS	MONTHS	DAY		
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MARYLAND		USA					CARROLL								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
WESTMINSTER		CARROLL LUTHERAN VILLAGE										HOUSEWIFE		OWN HOME	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		2157			
MD.		CARROLL		WESTMINSTER			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			239 ST. MARK'S WAY.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			FIRST		MIDDLE		LAST		HORTON				
GEORGE		EFFIE													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO		217-36-4270		CARROLL LUTHERAN VILLAGE WESTMINSTER		NAOMIE MYERS 239 ST MARK'S WAY MD		2157		3 yrs					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												18c			
4292 CANDID PULMONARY ARREST												3 yrs			
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD												15 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
		P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) this hospital attended the deceased from 5/8/83 to 19, 1983, to 10, 1983, that (1) we lost saw the deceased alive on 8/12/83, 1983, and that (1) my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we did (did not) view the body after death.															
22b. SIGNATURE DEGREE															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED				
JOHN KREIMER		104 N MAIN ST. UNION BRIDGE									8/29/83				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
BURIAL		SEPT 1-1983		ST PETERS			LIBERTYTOWN		MD		MD				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
D. D. G. & Sons		310 Church St.		Sept 2-1983		John J. Carroll									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death, if signed by the attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21671	
1. DECEASED NAME (TYPE OR PRINT)	FIRST <i>PAUL</i>	MIDDLE	LAST <i>LEIDY SR.</i>	2a. DATE OF DEATH MONTH YEAR 8 21 83	MONTH DAY YEAR	2b. HOUR 11:15 AM					
3. SEX <i>MALE</i>	4. RACE <i>CRUC.</i>	5. DATE OF BIRTH MONTH 12 DAY 17 YEAR 88'	6. AGE (IN YEARS LAST BIRTHDAY) 95. YRS	7a. IF UNDER 1 YEAR MONTHS 0	7b. IF UNDER 24 HRS HOURS 0						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL</i>								
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Westminster Nursing</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>MANAGER</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Hides, Tallow</i>								
13a. STATE <i>Md</i>	13b. COUNTY <i>CARROLL</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>57 S Colonial Ave</i>							
14. FATHER'S NAME FIRST <i>FRANCIS</i>	MIDDLE	LAST <i>Leidy</i>	15. MOTHER'S MAIDEN NAME FIRST <i>HANNA</i>	MIDDLE	LAST <i>Shire</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	16b. SOCIAL SECURITY NO. <i>213-01-9152</i>	17. INFORMANT <i>Russell E. Leidy</i>	ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4360</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <i>Hypertension</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 MONTH</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i>						2 yrs					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from show the deceased alive on <i>8/20/83</i> to <i>8/21/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						218 19 63	8/21 19 83	the (I) (we) lost			
22b. SIGNATURE <i>Julius Chepko M.D.</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8/24/83</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Julius Chepko</i>	22e. ADDRESS <i>85 W. Green St Westminster Md</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>8-24-83</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Westminster</i>	23d. LOCATION CITY OR TOWN <i>Westminster Carroll Md</i>								
24. FUNERAL DIRECTOR NAME <i>Robert Kyle Pruitt Jr.</i>	25a. ON PREMISES BY REGISTRAR <i>AUG 29 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>									

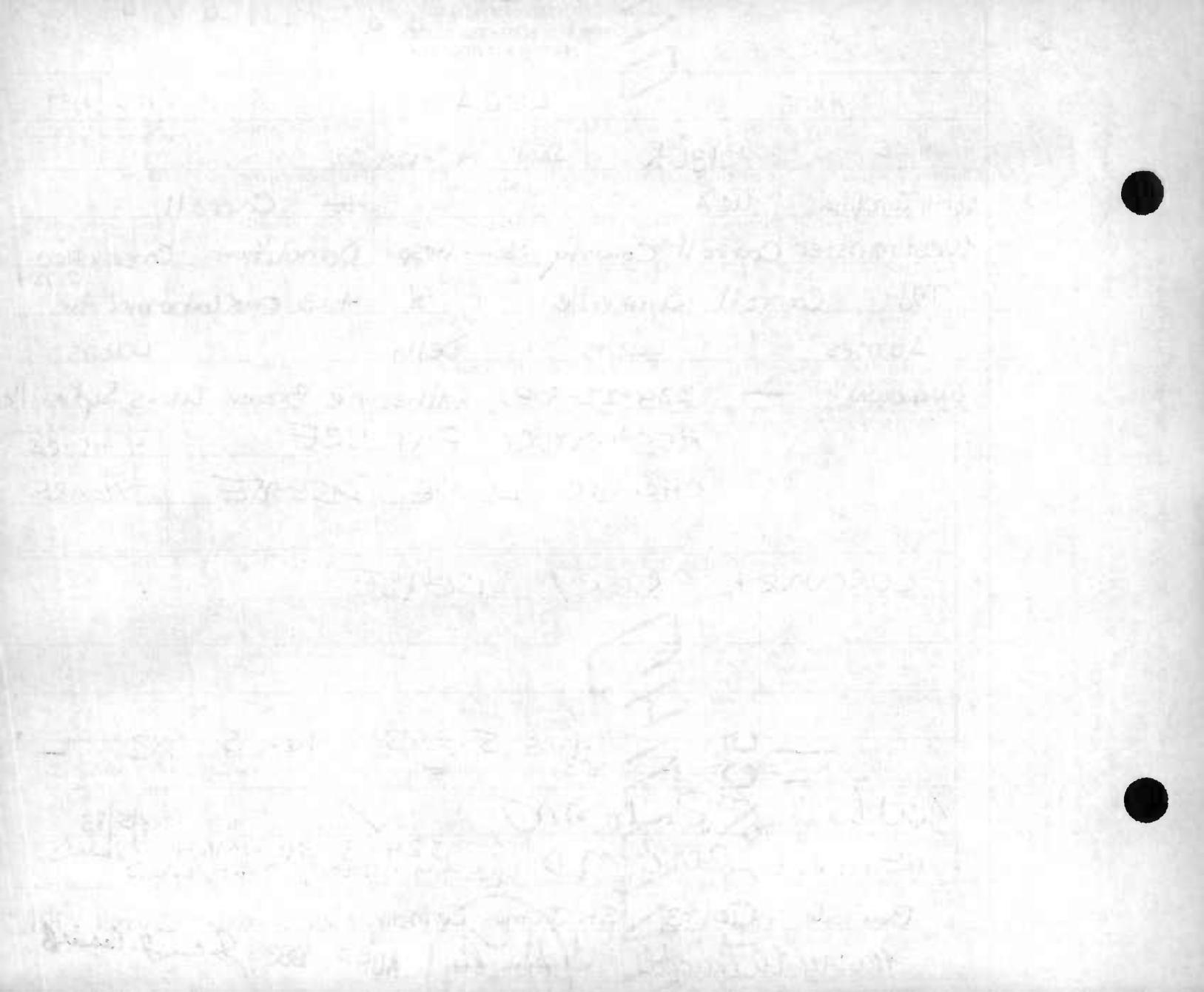


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 21578											
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
ARTIE							LUCAS			August 5 1983						2337 M							
3. SEX MALE			4. RACE Black			5. DATE OF BIRTH JAN 19 1924			6. AGE (IN YEARS LAST BIRTHDAY) 59			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll			10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hosp.			12a. USUAL OCCUPATION Demolition			12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Md			13b. COUNTY Carroll			13c. CITY OR TOWN Sykesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 413 Oklahoma Ave			21784								
14. FATHER'S NAME James			MIDDLE			LAST Lucas			15. MOTHER'S MAIDEN NAME Della			MIDDLE			LAST Lucas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. 238-22-3085			17. INFORMANT Katherine Brown			ADDRESS Lucas, Sykesville			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HOURS											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5188			18b. CHRONIC LUNG DISEASE			18c. DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC LUNG DISEASE			18d. DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: CORONARY ARTERY DISEASE																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (he/she) attended the deceased from AUG 5 1983 to AUG 5 1983, that (I) (he/she) last saw the deceased alive on AUG 5 1983, and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated above, (I) (he/she) did not view the body after death.																							
22b. SIGNATURE Arthur L. Rudo, MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/5/83														
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L. RUDO MD			22f. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MARYLAND																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/10/83			23c. NAME OF CEMETERY OR CREMATORIAL St. James Cemetery			23d. LOCATION CITY OR TOWN New Windsor			COUNTY Carroll			STATE MD								
24. FUNERAL DIRECTOR NAME Harry W. Haight			ADDRESS Sykesville			25a. DATE REC'D. BY REGISTRAR AUG 8 1983			25b. REGISTRAR'S SIGNATURE John J. Carroll														



TO HOSPITAL OR ATTENDING PHYSICIAN: The attained by the hospital or attending physician

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

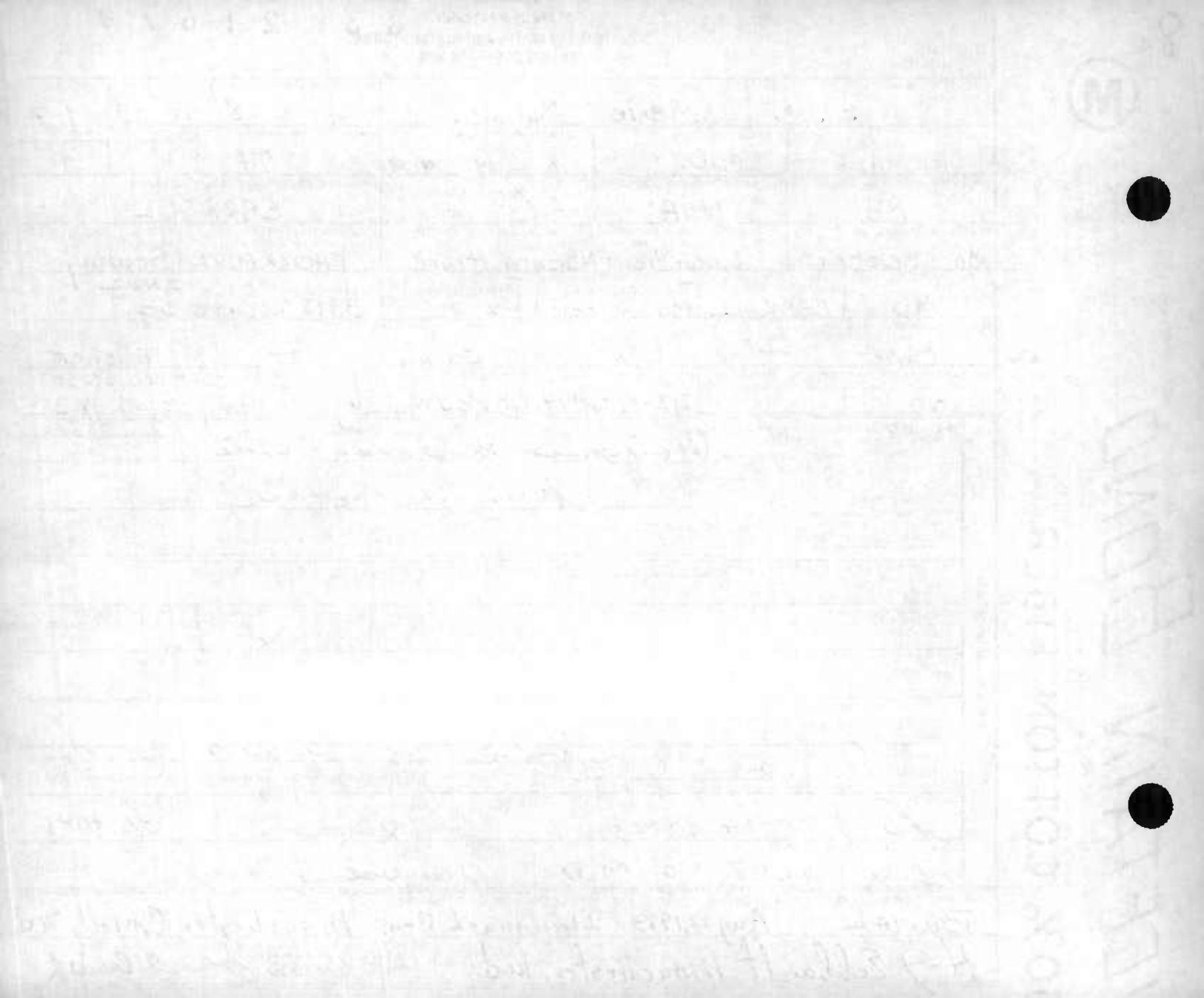
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21679

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Elsie Marie Mahaley						8 19 83					1 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE		CAUC.		MONTH	DAY	YEAR	74			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
Md.		USA					CARROLL					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Manchester		Long View Nursing Home					FACTORY WKR			Sewing		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21102	
MD		CARROLL		Manchester					3318 Locust St.			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST		ADDRESS			
		Oliver — Cox		Sarah					3318 Locust St			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		212-14-64604		Charles Mahaley			1729 Bilateral melanoma with main metastases					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any		(b)		DUE TO, OR AS A CONSEQUENCE OF main metastases								
		(c)		DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		
22a. I certify that (I) this hospital attended the deceased from June 19 1983 to August 19 1983, that (I) we last saw the deceased alive on August 19 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF <input type="checkbox"/>	22c. DATE SIGNED 8/1/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
D. V. Faustino M.D.		1803 Locust Street										
23a. BURIAL, CREMATION, REMOVAL (IF)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		25a. DATE REC'D. BY REGISTRAR			
BURIAL		Aug. 23, 1983		IMMANUEL CEM			MANCHESTER, CARROLL, MD		AUG 22 1983			
24. FUNERAL DIRECTOR NAME		ADDRESS		25b. REGISTRAR'S SIGNATURE								
H. J. Echholtz		Manchester, MD										



Item 5 per Ph. call from F.h.

STATE OF MARYLAND 8 3
11/16/83 JAB
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21680

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST Irene	MIDDLE Anna	LAST Mullhausen	2a. DATE OF DEATH August 9, 1983	MONTH AUG	DAY 9	YEAR 1983	2b. HOUR 1553 M	
3. SEX REMale			4. RACE White		5. DATE OF BIRTH 1909 MONTH 9 DAY 14 YEAR 83	6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN Baltimore Co.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll				
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY MD.				
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2947 Old Taneytown Rd. 21157		
14. FATHER'S NAME FIRST John			MIDDLE A.	LAST Raab	15. MOTHER'S MAIDEN NAME FIRST Alberta		MIDDLE		LAST Harple		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 219-60-8159		17. INFORMANT Joseph H. Mullhausen (same above)		ADDRESS				
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4140											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Heart Disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b <i>Diabetes mellitus</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 9, 1983</i> to <i>Aug 9, 1983</i> , that (II) (we) last saw the deceased alive on <i>Aug 9, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John S. Harple</i>			22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 8/7/83			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) John S. HARPLE MD			22g. ADDRESS 8 Andrew St. Westminster, Md. 21157								
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial			23b. DATE 8-12-83		23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHN'S CEMETERY		23d. LOCATION CITY OR TOWN Westminster		COUNTY Carroll	STATE Md.	
24. MEDICAL DIRECTOR <i>Thomas D. Fletcher</i>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Thomas D. Fletcher & Son 254 East Main Street Westminster, Md. 21157 AUG 11 1983 John J. Conroy								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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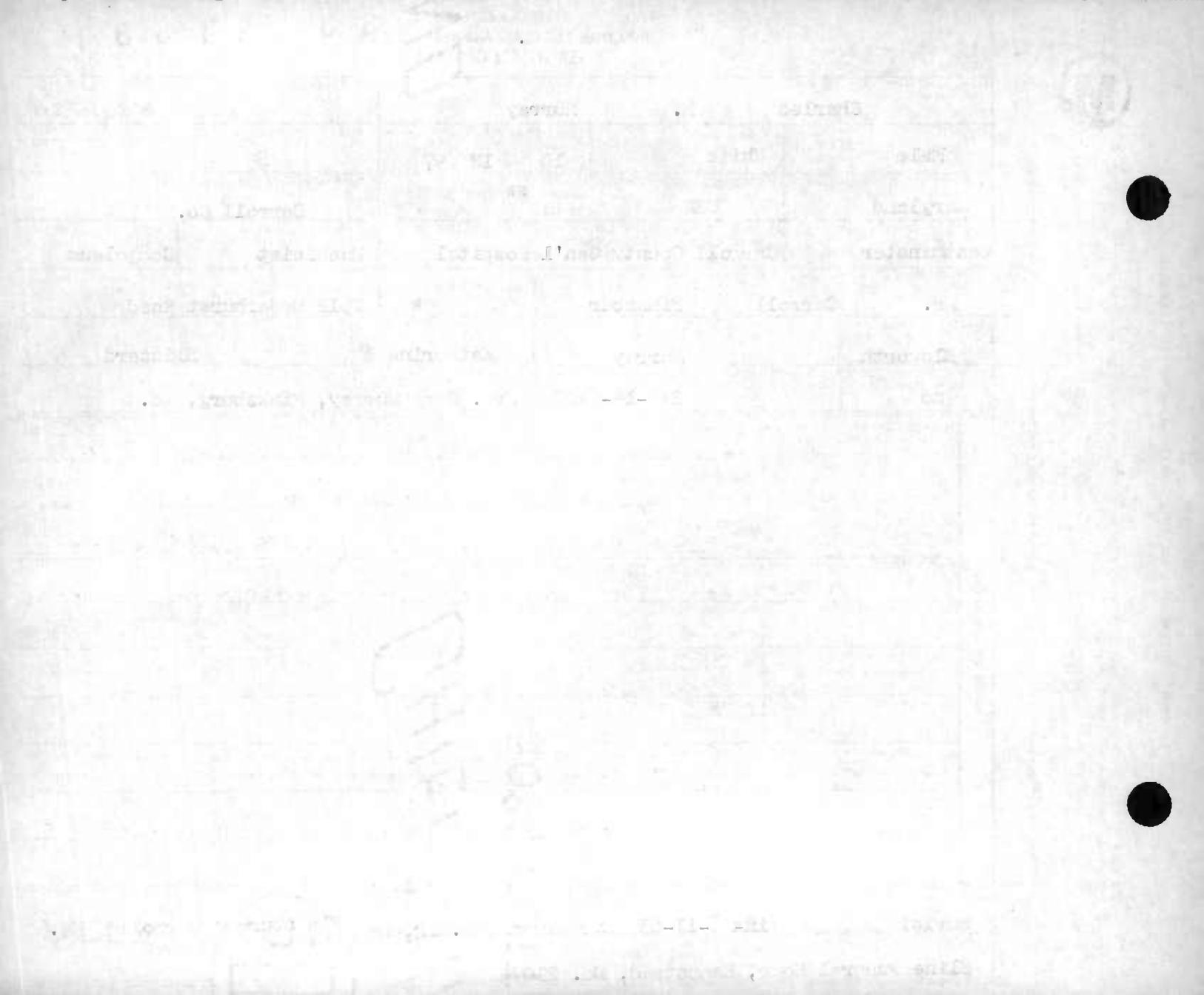
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	2	1	6	8	1	
										REG. NO.							
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Charles E. Murray						8 9 83						1530 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			MONTH 10 DAY 12 YEAR 97			85 YRS.			MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll Co.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Westminster			Carroll County Gen'l Hospital			Machinist			Congoleum			21074					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										21074							
13a. STATE Md.			13b. COUNTY Carroll			13c. CITY OR TOWN Finksburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2912 Cedarhurst Road					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST					
Elsworth			Murray						Katherine			Blizzard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no			212-14-6103			17. INFORMANT Mrs. Mary Murray, Finksburg, Md.						3 DAYS					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										ACUTE RESPIRATORY INSUFFICIENCY							
4360																	
DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c) DUE TO, OR AS A CONSEQUENCE OF CEREBRAL VASCULAR INSUFFICIENCY WEEKS																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
MULTIPLE PREVIOUS CEREBRAL VASCULAR ACCIDENTS																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/17 1983 to 8/19 1983, that (I) (we) last saw the deceased alive on 8/19 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 8/19/83							
22b. SIGNATURE <i>Robert J. Jones Jr. MD</i>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT)										22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10x 8-11-83			23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Mem. Gardens			23d. LOCATION CITY OR TOWN Finksburg			COUNTY	STATE				
Burial												Carroll	Md.				
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074										25a. DATE REC'D. BY REC'D. BY AUG 11 1983		25b. SIGNATURE <i>John G. Gandy</i>					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1-
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
Michael			Patrick	Murray		<input checked="" type="checkbox"/>	8	21	1983	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	White	9-4-58	24 yrs.			8	21	1983	8:50 P.M.	

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Md.	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Carroll County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Rt. 26 & Whiterock Road	Electrician	Electric

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS
Md.	Carroll	Sykesville		2012 Sherry Ave

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	Frederick	Murray Sr.	Regina		Herrmann

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS
Yes	Army	?	John Murray, Sr. Sykesville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Multiple Injuries 8122 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.	
(b)	
(c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 7:59 P.M. 8 21 1983	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) operator of motorcycle impacted auto

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road	21f. LOCATION STREET CITY OR TOWN Rt. 26 & Whiterock Rd., Sykesville, Carroll Co.

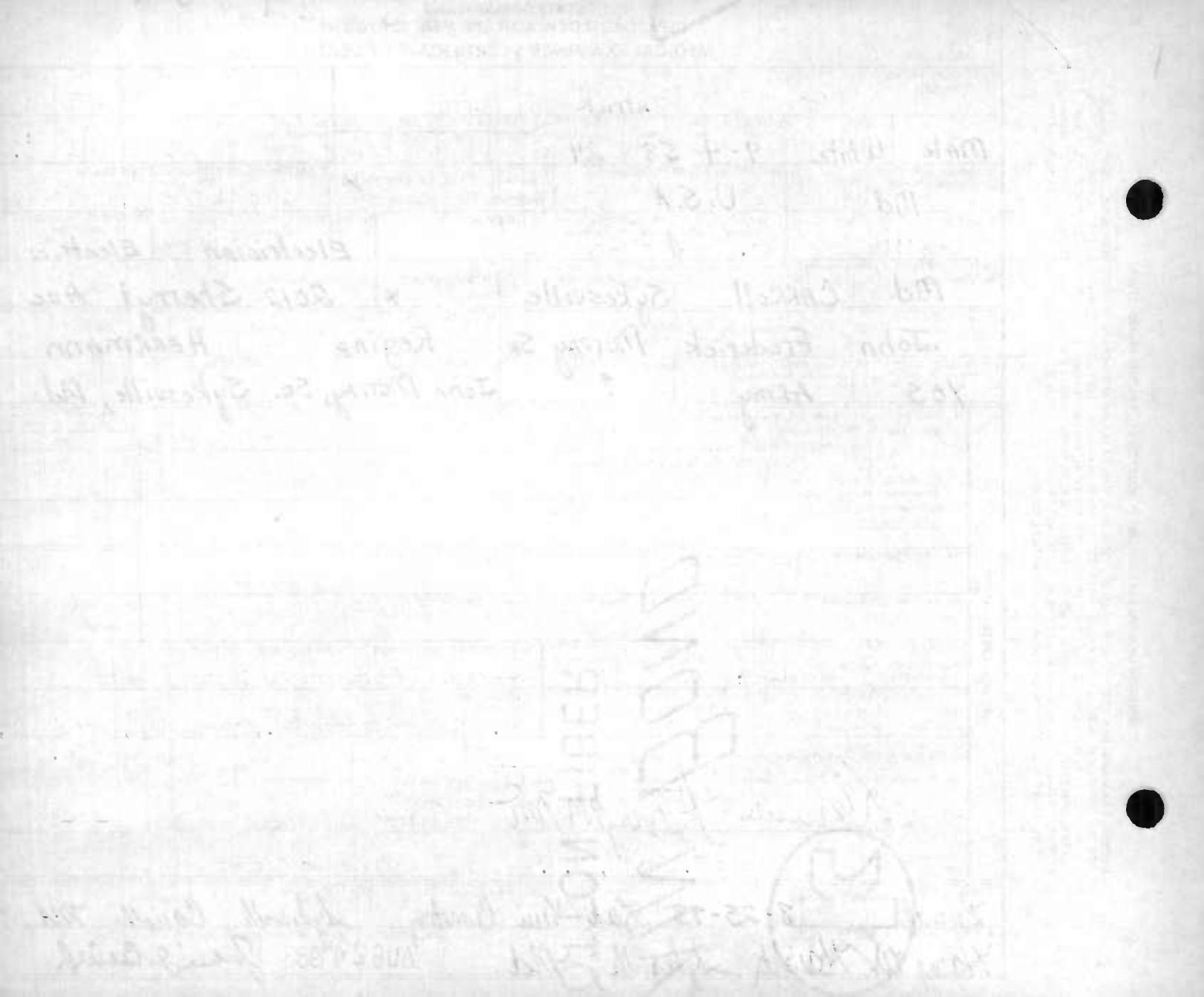
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion

ACTUAL SIGNATURE Dennis F. Smyth, M.D.	TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER

EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS	111 Penn Street
Dennis F. Smyth, M.D.		

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 8-25-83	23c. NAME OF CEMETERY OR CREMATORIUM Lake View Cemetery	23d. LOCATION CITY OR TOWN Sykesville

24. FUNERAL DIRECTOR Name John W. Haight	ADDRESS Sykesville, Md.	25a. DATE REC'D. BY REGISTRAR AUG 24 1983	25b. REGISTRAR'S SIGNATURE John J. Cawie



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 21083				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ISABEL	Ruth		MYERS	8-26-83				2:19 P	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR (MONTHS DAYS)	
FEMALE	CAUCASIAN	MONTH	DAY	YEAR	61	YRS.	IF UNDER 24 HRS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.						CARROLL		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
MILLERS	WESTMINSTER 4446 MILLER ST RD					Bookkeeper			BANKING
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21107
MARYLAND	CARROLL	MILLERS				4446 MILLER ST. RD.			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS		
Charles	V.	MASEMOR		MAMIE M. CAMERON			4446 Miller St. Rd.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no	213-16-1097			Carroll H. Lawyers Millers, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
1749 Carcinoma of breast, metastatic 3 years									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 26 August 1983, to 26 August 1983, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jim Zimmerman MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> DATE SIGNED 26 August 83									
22c. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES G. ZIMMERMAN, MD ADDRESS CARRILL COUNTY GENERAL HOSP WESTMINSTER, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL IMMANUEL			23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE		
BURIAL	Aug. 29, 1983	IMMANUEL CEM			MANCHESTER	CARROLL	MD		
24. FUNERAL DIRECTOR NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
N. J. Echhardt	Manchester, Md			AUG 29 1983			John J. Cawley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 21684									
1. FOR STATE REGISTRAR											REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR									
STANLEY			C.	S.	PERRY	8	28	83				11:35 AM									
3. SEX		M	4. RACE		W	5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 1 YEAR MONTHS DAYS									
Pennsylvania			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll Co. MD.			IF UNDER 24 HRS HOURS MIN.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
Westminster		Carroll County Gen'l Hospital										Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Construction							
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			99999										
Pa.		Luzerne	Nanticoke		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			686 East Main Street													
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT							
Stanley				Perry	Florence			yes			206-10-7430			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														2 HRS							
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u>														2 WEEKS.							
DOUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC HEART DISEASE</u>														—							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>CONGESTIVE HEART FAILURE, DIABETES MELLITUS.</u>																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>8-14-83</u> to <u>8-28-83</u> , that (I) <input type="checkbox"/> lost saw the deceased alive on <u>8-28-83</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> not view the body after death.														22b. SIGNATURE <u>G.V. Prasad</u>		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE										
G.V. PRASAD.		CARROLL COUNTY HOSPITAL			Nanticoke Cemetery			Nanticoke			Luzerne Pa.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		25a. DATE REC'D. BY REGISTRAR									
Burial		8-31-83		Nanticoke Cemetery		Nanticoke		Luzerne		Pa.		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>									
24. FUNERAL DIRECTOR NAME		ADDRESS			25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE														
Eline Funeral Home, Hampstead, Md.		21074			AUG 30 1983																

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR 2 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	21685										
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR			2b. HOUR					
GEORGE			W.			Pickett						8 26 1837			10:00			M					
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR			
Male		White		2 27 1920			63 yrs.			MONTHS		DAYS		HOURS		8 26 183			9:00			M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		USA								Carroll Co.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Westminster		Carroll County Gen'l Hospital												Trackman			Railroad						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			21048										
Md.		Carroll		Finksburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1209 Wesley Road													
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			LAST									
		Jacob						Pickett			Gertrude			Masenheimer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
yes		WW2			705-14-0126			Mrs. Beulah Pickett, Finksburg, Md.						Hypertensive Cardiovascular									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>decease</i> DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?								
															YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>			and in my opinion																	
ACTUAL SIGNATURE			M.D.			TITLE (SPECIFY)						MEDICAL EXAMINER			DATE SIGNED								
EXAMINER'S NAME (TYPE OR PRINT)															26 Aug 83								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE								
Burial			8-29-83			Evergreen Mem. Gardens			Finksburg			Carroll			Md.								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY BURIAL/CREMATORIAL REGISTRATION																	
Eline Funeral Home. Hampstead, Md. 21074						AUG 30 1983																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21686

1. DECEASED NAME (TYPE OR PRINT)			FIRST LECKIE	MIDDLE Louise	LAST REED	2a. DATE OF DEATH MONTH 8	DAY 11	YEAR 83	2b. HOUR 1745 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 7	DAY 28	YEAR 98	6. AGE (IN YEARS LAST BIRTHDAY) 85	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll				
10. CIRCUMSTANCES OF DEATH 21157	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster	12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) Maryland Carroll Union Bridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 14. Whyte St.	13f. BUSINESS OR INDUSTRY clothes processor center		
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Union Bridge	15. MOTHER'S MAIDEN NAME Mellie	16. FATHER'S NAME William Reid	17. INFORMANT Robert L. Reed	18. ADDRESS Thurmont, MD	19. LAST NAME Akers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. none	16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4151 pulmonary embolus						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			DUE TO, OR AS A CONSEQUENCE OF (b)						
			DUE TO, OR AS A CONSEQUENCE OF (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I hypertension, chronic bronchitis, atrial fibrillation									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	19b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/11 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			7/28 19 83	to 8/11 19 83					
22b. SIGNATURE D. W. Espenshade, Jr. MD			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/11/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Park W. Espenshade, Jr.			22e. ADDRESS 419 Malcolm Drive Westminster, MD						
23a. FUNERAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/14/83	23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery	23d. LOCATION near town	23e. COUNTY Carroll	23f. STATE MD				
24. FUNERAL DIRECTOR NAME D. D. Hartler	ADDRESS Union Bridge, Md.	25a. DATE REC'D. BY REGISTRAR AUG 17 1983	25b. REGISTRAR'S SIGNATURE John G. Conner						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21681	
											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
EVA			Daniel	REYNOLDS		8	-	1	-	83	120 P M		
3. SEX Female			4 RACE cauc	5. DATE OF BIRTH MONTH 7	DAY 5	YEAR 1892	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS 91	IF UNDER 24 HRS HOURS YRS		
7a. BIRTHPLACE COUNTRY VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL			MD.			
10. CITY OR TOWN OF DEATH MANCHESTER			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long View Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY WESTMINSTER				
13a. STATE MARYLAND			13b. COUNTY CARROLL	13c. CITY OR TOWN WESTMINSTER	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 31 1/2 W. minst			MD 21157		
14. FATHER'S NAME Charles			MIDDLE	Williams	15. MOTHER'S MAIDEN NAME Berta			MIDDLE	LAST	Anne			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 520-01-08390			17. INFORMANT Hilda Anne Watkins 319 Margaret Ave			ADDRESS 21157 WESTMINSTER MD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			CEREBRO VASCULAR ACCIDENT			DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC			CARDIO-VASCULAR				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.						DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>NEVER SEEN BEFORE</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Meyers			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/1/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. D. MORIARIA			22e. ADDRESS 3125 MAIN STREET, MANCHESTER, MD 21102										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-4-83			23c. NAME OF CEMETERY OR CREMATORIAL Westminster Cemetery			23d. LOCATION CITY OR TOWN Westminster				
24. FUNERAL DIRECTOR Thomas D. Fletcher & Son 254 East Main St. Westminster, Md.			25a. DATE REC'D. BY REGISTRAR 21 AUG 8 1983			25b. REGISTRAR'S SIGNATURE John J. Carroll							
BP _____													
DHMH-16 50M 1/81 (VRA 15, 4)													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21088			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Louise H. Simmons						8 23 83			0220 M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		9 19 1909			73 yrs.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.						
Maryland		USA											
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen'l Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rehab. Director		12b. KIND OF BUSINESS OR INDUSTRY State Hospital	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 211 St. Matthew Ct.			
14. FATHER'S NAME FIRST Arthur		MIDDLE L.		LAST Howeth			15. MOTHER'S MAIDEN NAME Lulu			16. ADDRESS J. Boyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-38-0060		17. INFORMANT Mr. Wilbur J. Simmons, Westminster, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACTIBLE CONGESTIVE HEART FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MOS													
4140 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>MASSIVE MYOCARDIAL INFARCTION</u> " "													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>UREMIA . ARTERIOULAR NEPHROSCLEROSIS</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6/22 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 8/23/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Vincent J. Deacon Jr. MD</u>		22e. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-25-83			23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery			23d. LOCATION CITY OR TOWN Woodlawn		COUNTY Balto	STATE Md.		
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074		25a. DATE REC'D. BY REGISTRAR AUG 25 1983								25b. REGISTRAR'S SIGNATURE <u>John J. Lovell</u>			

THE HOSPITAL, OR ATTENDING PHYSICIAN. The few requirements that this death certificate be executed in 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

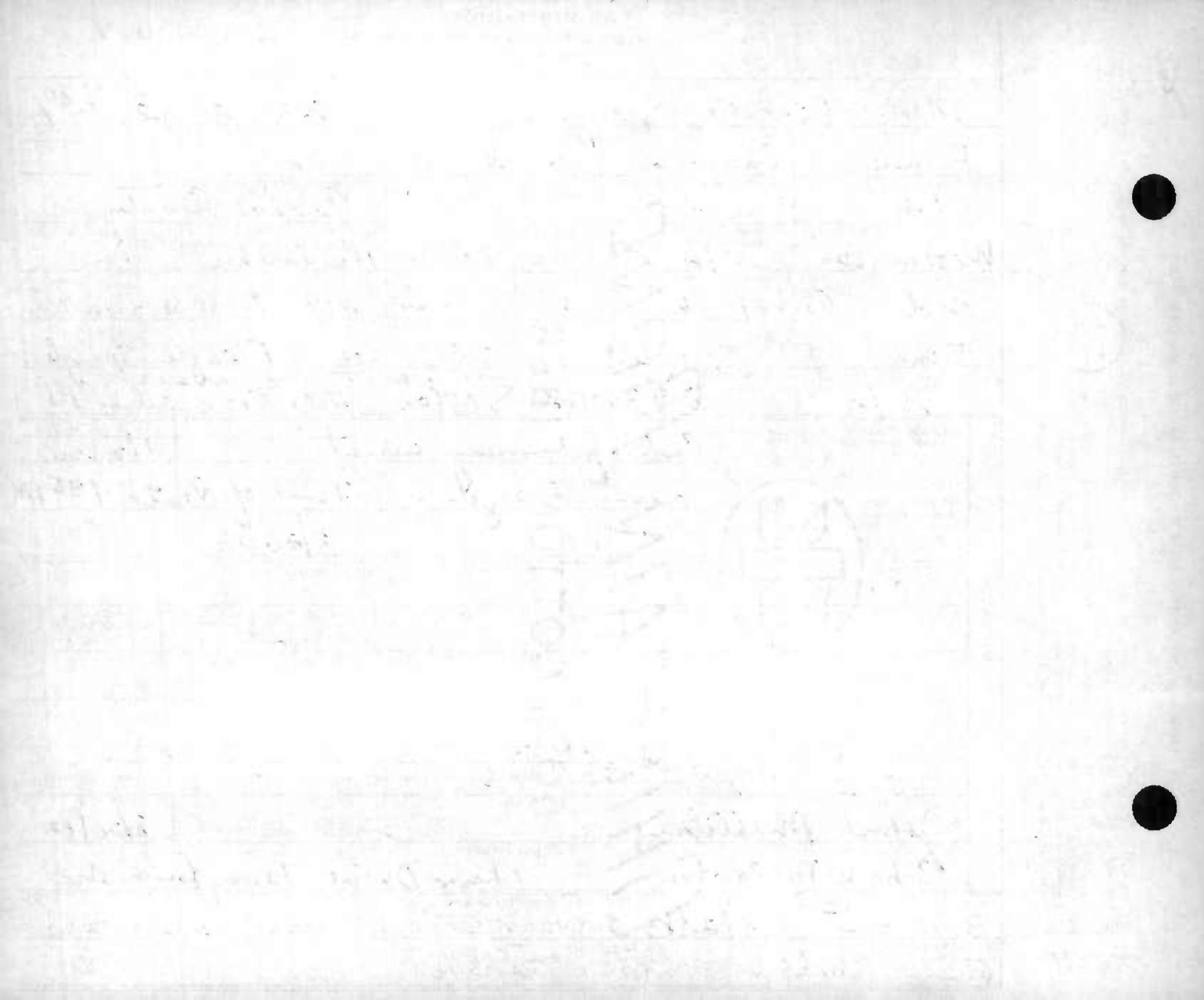
1 - FOR
STATE
REGISTRATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21689

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Isabelle Spangler			2a. DATE OF DEATH MONTH DAY YEAR 68 26 83	2b. HOUR 1/2 HOUR 4 PM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6 20 95	6. AGE (IN YEARS LAST BIRTHDAY) 88	7a. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7c. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County		
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN DEATH TOWN, GIVE STREET ADDRESS) 2501 Cross Section			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2501 Cross Section Rd	
14. FATHER'S NAME FIRST MIDDLE LAST John C Spangler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Lee Fleagle Spangler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNK) No			16b. SOCIAL SECURITY NO. 219-360178	17. INFORMANT IMMEDIATE CAUSE (a) 4960 <i>Cardio pulmonary arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hr	
DUE TO, OR AS A CONSEQUENCE OF (b) advanced age			Time of death 4:35 PM		
DUE TO, OR AS A CONSEQUENCE OF (c) COPD			8/26/83		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) COPD					
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —	21f. LOCATION STREET —	CITY OR TOWN —	COUNTY —	STATE —
22. I certify that (I) (this hospital) attended the deceased from 1976 , 19 — , to 1983 , 19 — , that (I) (we) lost sow the deceased alive on August 1st 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE John W Middleton			22b. DEGREE —		
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/26/83		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Middleton			22f. ADDRESS 1 King Drive Taneytown MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/29/83	23c. NAME OF CEMETERY OR CREMATORIUM GRACE REFORM	23d. LOCATION CITY OR TOWN TANEY TOWN CARROLL	23e. COUNTY —	23f. STATE —
24. FUNERAL DIRECTOR NAME Rickard Clucke	24a. ADDRESS 34 MAPLE ST	24b. DATE REC'D. BY REGISTRAR 31 AUG 1983	25b. REGISTRAR'S SIGNATURE —		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
HOLLUS C. UNDERWOOD												08 21 83				05 15 M	
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS		
FEMALE			WHITE			MONTH 12 DAY 21 YEAR 04			78			MONTHS YRS.			HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
MARYLAND			U.S.A.						CARROLL COUNTY						DOMESTIC		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b. STREET ADDRESS			13a. STATE			13b. COUNTY		
WESTMINSTER			CARROLL COUNTY GENERAL HOSPITAL			HOUSEWIFE			217881784			MARYLAND			EDWARD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		
WILLIAM			AMELIA C. BAKER			NO			213-38-6386			CHARLES W. UNDERWOOD			IMMEDIATE CAUSE (a) CARDIAC ARREST		
2030			DUE TO, OR AS A CONSEQUENCE OF (b) HYPERCALCEMIA			30 mts.			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a			DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE MYELOMIA			unknown.		
2030			DUE TO, OR AS A CONSEQUENCE OF (b) HYPERCALCEMIA			6 months											
21a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-20-83 19 to 8-21-19 83, that (I) (we) last saw the deceased alive on 8-20 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE G. V. PRASAD			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. V. PRASAD.			22e. ADDRESS CARROLL COUNTY GEN. HOSP. WESTMINSTER														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-23-83			23c. NAME OF CEMETERY OR CREMATORIAL SPRINGFIELD CEMETERY			23d. LOCATION CITY OR TOWN SYKESVILLE			23e. COUNTY CARROLL			23f. STATE MARYLAND		
24. FUNERAL DIRECTOR NAME Harry W. Hugitt			ADDRESS Lykens, Md.			25a. DATE REC'D. BY REGISTRAR AUG 22 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please move carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21691	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH, MONTH DAY YEAR			2b. HOUR		
Mayelle F. Wagner			Wagner			8 10 '83			10:15 AM		
3. SEX ♀ FEMALE			4 RACE WHITE			5. DATE OF BIRTH MONTH 4 DAY 14 YEAR 96			6. AGE (IN YEARS LAST BIRTHDAY) 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Baltimore Reg & Carroll. Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC 21794		
13a. STATE Md.			13b. COUNTY HARFORD			13c. CITY OR TOWN West Friendship			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE ERNEST RUDOLF			15. MOTHER'S MAIDEN NAME MIDDLE ALICE			16. SOCIAL SECURITY NO. 214-03-2557			17. INFORMANT AUDREY HOFFMAN		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -			18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs			18c. IMMEDIATE CAUSE (a) 4292			18d. DUE TO, OR AS A CONSEQUENCE OF (b) (c)		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (his hospital) attended the deceased from 06-06, 19 80, to 8-10, 19 83, that (I) (we) last saw the deceased alive on 8-8, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (did) view the body after death.											
22b. SIGNATURE Alva S. Baker (MD)			DEGREE			22c. DATE SIGNED 8-10-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alva S. Baker			22e. ADDRESS 218 Washington Heights Medical Center Westminster MD 21157								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-13-83			23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK CEMETERY			23d. LOCATION CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE		
24. FUNERAL DIRECTOR NAME HAIGHT FUNERAL HOME			ADDRESS SYKESVILLE, MD			25a. DATE REC'D. BY REGISTRAR AUG 17 1983			25b. REGISTRAR'S SIGNATURE S. G. C. G.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND										DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 21692			
1. FOR STATE REGISTRAR		2. DATE OF DEATH										MONTH	DAY	YEAR	26 HOUR						
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		3. DATE OF BIRTH		MONTH	DAY	YEAR	26 HOUR								
Estella G Wentz						Wentz		4. RACE		5. DATE OF BIRTH		August 12, 1983		1030 PM							
3. SEX		F		Cauc				MONTH		DAY	YEAR										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Carroll, MD		7b. CITIZEN OF WHAT COUNTRY?		U.S.A.		8. MARRIED		NEVER MARRIED											
								WIDOWED		DIVORCED											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
Manchester		Long View Nursing Home										Housewife									
13a. STATE		Md.		13b. COUNTY		Carroll		13c. CITY OR TOWN		Westminster		12b. KIND OF BUSINESS OR INDUSTRY									
												21157									
14. FATHER'S NAME		Charles		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST							
								Loura						Geiman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		No		16b. SOCIAL SECURITY NO.		212-16-2586		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
												5 yrs									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a)										PART II. TERMINAL DISEASE OR CONDITION artherosclerotic Cardiovascular Disease 5 yrs									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.		(b) Generalized arteriosclerosis 5 yrs																			
		(c) Cerebral vascular insufficiency 2 yrs																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21e. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																					
22a. I certify that (1) this hospital attended the deceased from 7/18, 1983, to 8/12/83, that (2) we did not view the body after death.																					
22b. SIGNATURE		W.H. Ford MD										DEGREE	22c. DATE SIGNED								
		W.H. Ford MD											8/12/83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										3223 Main St Box E									
Burke		8/16/83										Manchester, Md 21162									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE											
Burial		8/16/83		John Luther Miller Crem. Co.		Westminster		Carroll		Md											
24. FUNERAL DIRECTOR		ECKHARD FUNERAL ADDRESS										25a. DATE REC'D. BY REGISTRAR									
B. Lang Nightingale		CHAMBER MANCHESTER, MD										AUG 17 1983									
												John & Conie									

NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

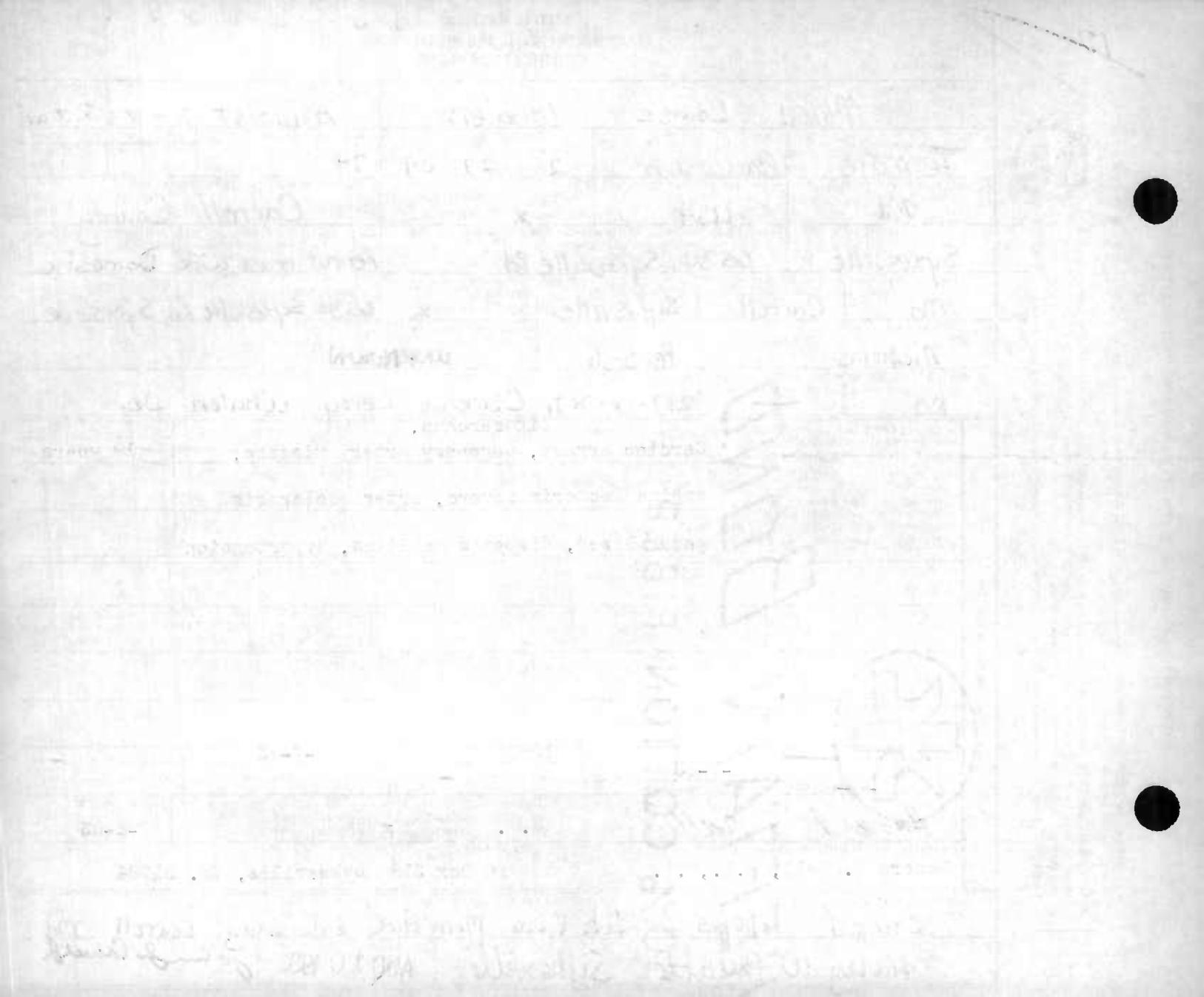
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 2 1 6 9 3				
1 - FOR STATE REGISTRAR												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Russell Edwin Wetzel									8 15 83					0829M		
3. SEX Male			4. RACE White		5. DATE OF BIRTH 12 th / 31 st / 11		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS HOURS		9. IF UNDER 24 HRS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll		10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) Westminster Carroll County Gen. 21157		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY State Roads	
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Linwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 245 Clear Ridge Rd.		14. FATHER'S NAME John E. Wetzel		15. MOTHER'S MAIDEN NAME Margaret Fowler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W W II		16c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100		17. INFORMANT Ruth Wetzel		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a C.O.P.O.					
19a. DATE OF OPERATION 9/9			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-14 19 83 to 8-15 19 83, that (I) (we) last saw the deceased alive on 8-15 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 8-15-83				
22b. SIGNATURE MANUEL J. SEVILLA			22c. DEGREE MANUEL J. SEVILLA		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 419 CALLEGORN DR. WESTMINSTER									
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 8/17/83		23c. NAME OF CEMETERY OR CREMATORIAL Rocky Hill Cem		23d. LOCATION CITY OR TOWN Woodsboro		23e. STATE RURAL							
24. FUNERAL DIRECTOR D. S. Brantley			25a. ADDRESS New Windsor, Md.		25b. DATE REC'D. BY REGISTRAR AUG 16 1983		25c. REGISTRAR'S SIGNATURE John J. Conner									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND 8 3 2 1 6 9 4 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Mary Louise Whalen						August 7-83 8:00 AM					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		
Female			Caucasian			2 27 09			74 IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
Md			USA								
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6534 Sykesville Rd			12a. USUAL OCCUPATION Retired house wife Domestic			12b. KIND OF BUSINESS OR INDUSTRY 21784		
13a. STATE Md		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 6534 Sykesville Rd, Sykesville		
14. FATHER'S NAME Nicholas			LAST Perbish			15. MOTHER'S MAIDEN NAME UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO			17. INFORMANT Clarence Leroy Whalen Jr.			ADDRESS Liposarcoma, 10 years		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years		
1719			Angina Pectoris severe, arteriosclerosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)								
			DUE TO, OR AS A CONSEQUENCE OF (b)								
			generalized, diabetes mellitus, hypertension								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 8-7-83			1960 19 to 8-7-83 19								
saw the deceased alive on 8-7-83			19			and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (he) (she) (did not) view the body after death.					
22b. SIGNATURE Howard E. Hall			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-8-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard E. Hall, M.D., P.A.			22e. ADDRESS PO Box 318 Sykesville, Md. 21784								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/10/83			23c. NAME OF CEMETERY OR CREMATORIAL Yule View Mem Park			23d. LOCATION CITY OR TOWN Eldersburg COUNTY Carroll STATE Md.		
24. FUNERAL DIRECTOR NAME Harry W Haught			ADDRESS Sykesville			25a. DATE REC'D. BY REGISTRAR AUG 10 1983			25b. REGISTRAR'S SIGNATURE John G. Carroll		
BP											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at this time.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21695							
										REG. NO.							
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		Frank Jerry White									8 11 83					4350 M	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male		Black			MONTH DAY YEAR			59			MONTHS DAYS		HOURS MIN.				
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland		U.S.A.						Carroll County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Sykesville		Springfield Hospital Center						railroad worker									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland		Frederick		Frederick		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			431 W. South St.		21701						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
		Samuel	Joseph	White	Theresa			219-12-1807		Records: Springfield Hospital Center							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
No																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)			20. Stage III			21. Pulmonary carcinoma			months						
		1629															
PART 1. DEATH WAS CAUSED BY:		DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Jae m. Park, M.D.			22c. DEGREE			22d. ADDRESS			22e. DATE SIGNED 8-11-83						
								Springfield Hospital Center Sykesville, Maryland 21784									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE						
Burial		8/15/83		Fairview Cemetery			Frederick		Frederick		Md.						
24. FUNERAL DIRECTOR NAME		1621 Opossumtown Pike			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
G. Douglas Stauffer, Frederick, Md. 21701											AUG 24 1983						
BP																	
DHMH-16 50M 1/81 (VRA 15, 4)																	

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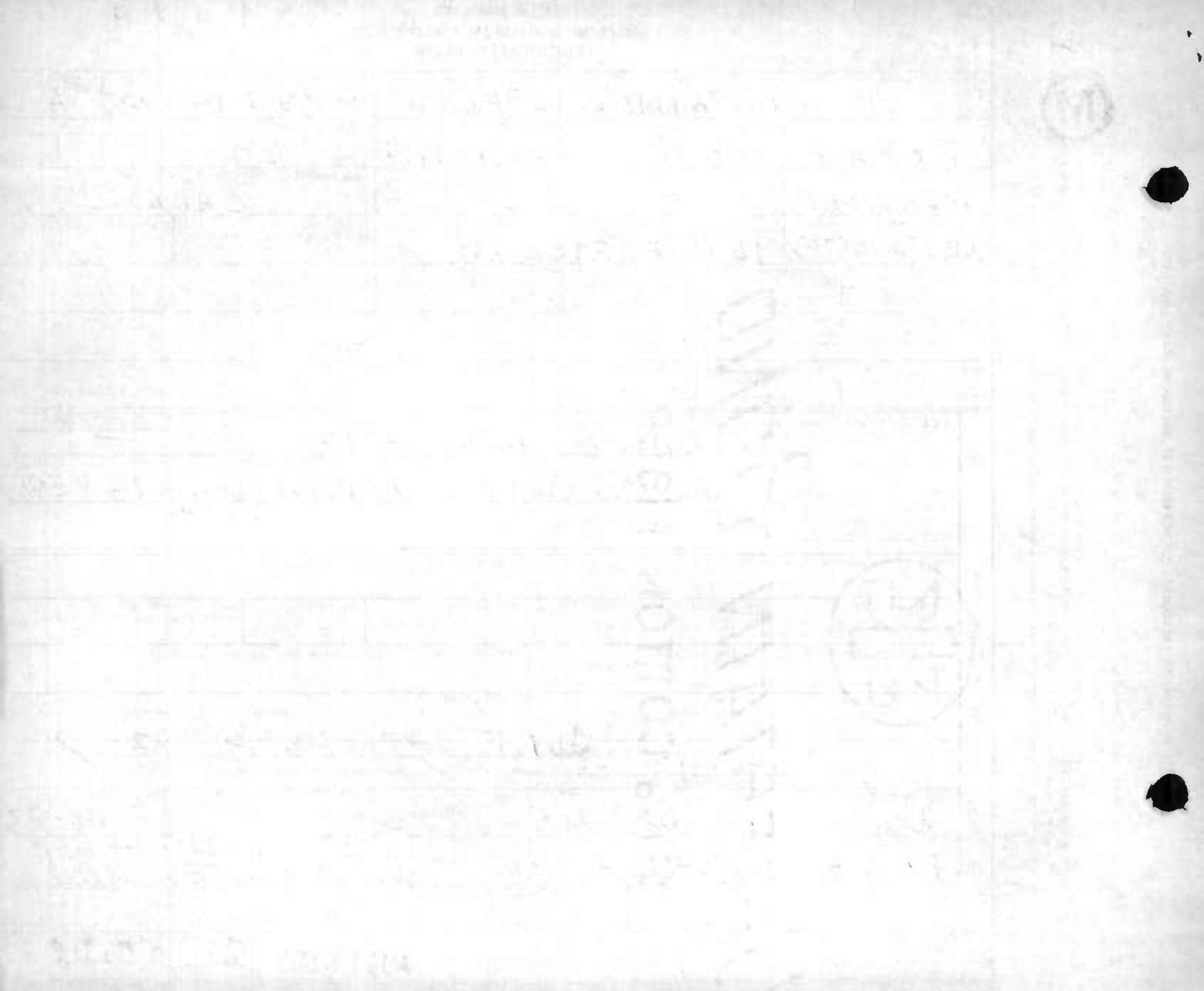
W. H. G. 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. B 3 21696					
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Veronica			WINAFREY WILDERSON			WILDERSON			AUGUST 14 1983			A					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
FEMALE		WHITE		MARCH 10 1914			69			MONTHS	YEARS	MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			CARROLL MD.							
MARYLAND		U.S.A.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER		1605 EXETER RD. 21157										Book Keeper					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Maryland		Carroll		Westminster			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1605 Exeter Road		21157					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST										
		Unknown		Wisniewski						Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
No		215-05-6896		Mr. Elwood R. Wilderson						1605 Exeter Road Westminster, MD. 21157							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4292 CARDIAC ANAYTHMIA															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										154 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		P.M.		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 13 1983</u> to <u>Aug 14 1983</u> , that (I) (we) last saw the deceased alive on <u>Aug 13 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Daniel Welliver M.D.		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 8-14-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I WELLIVER M.D.		22e. ADDRESS 210 WASHINGTON HEIGHTS WESTMINSTER MD.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 8-16-83		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Mausoleum		23d. LOCATION CITY OR TOWN Pikesville		COUNTY Baltimore		STATE Maryland			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133		25a. DATE REC'D. BY REGISTRAR AUG 17 1983		25b. REGISTRAR'S SIGNATURE John G. Leib													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND 83 21691 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR				
DAN			A.				WOODWARD		8 1 83		2325P				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.					
Male		White		Sept. 18, 1895		87									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.							
Virginia		USA				Carroll County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll County Gen. Hosp.										Steam fitter		G&E	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Md.		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21136					
Baltimore		Reisterstown						335 Highfalcon Rd.							
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
John					Woodward		Margaret				Jackson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Md.						
Yes			W.W.I		236-12-3267		Mrs. D. Irene Woodward Reisterstown,								
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>trivial artery thrombosis progressive cerebrovascular insufficiency</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/1 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		7/29 83		19 83		8/1 19 83									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
John J. Engenhardt, M.D.										8/1/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
Burial		Aug. 4, 1983		Greenlawn Cemetery		Williamsport, Washington,		Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY							
Burial		Aug. 4, 1983		Greenlawn Cemetery		Williamsport, Washington,		Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Eline Funeral Home		Reisterstown, Md.		AUG 4 1983		John J. Canfield									

